Department of Medicine

"AS THE CHAIRMEN SAW IT"

Volume One

In an ongoing series of histories by former Chairmen of the Department of Medicine

DR. JOHN W. SCOTT - 1944 - 1954
DR. DONALD R. WILSON - 1954 - 1969
DR. ROBERT S. FRASER - 1969 -1974

University of Alberta

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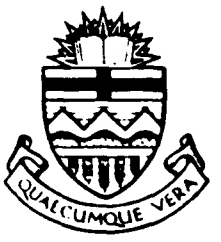

THE UNIVERSITY OF ALBERTA
DEPARTMENT OF MEDICINE

" AS THE CHAIRMEN SAW IT "

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DEPARTMENT OF MEDICINE CHAIRMEN

Back: Dr. George D. Molnar (1975-1986), Dr. Brian J. Sproule (1974-75)
Front: Dr. Robert S. Fraser (1969-1974), Dr. John W. Scott (1944-1954)
Dr. Donald R. Wilson (1954-69)
Missing: Dr. Edgerton Pope (1923-44)

HISTORY OF THE DEPARTMENT OF MEDICINE

JOHN W. SCOTT

PROFESSOR AND CHAIRMAN

DEPARTMENT OF MEDICINE

(Also Dean of Medicine during this time)

1944 to 1954

March 1979

My earliest recollection of medical teaching at the University of Alberta dates back to 1914.

The School of Medicine under the Faculty of Arts and Science had been organized in 1913, as a three year school. Students at the end of a three year course in Medicine were accepted for the final two years at McGill University and the University of Toronto. Alberta continued for ten years as a three year School. I recall that in 1914 the only bridge between North and South Edmonton was the Low Level Bridge. To reach the University from the north side one either walked across the river ice in winter or took a trolley car over the Low Level Bridge which travelled up 99th Street and along 82nd Avenue to a turn around about the junction of 82nd Avenue and 109th Street. From there one walked along a trail in dense bush to Assiniboia Hall or Athabasca Hall which were the only University Buildings in 1914. The Registrar's Office was located in Assiniboia Hall. Mr. Cecil Race, the Registrar, was a very kindly gentleman, who after examining my credentials indicating that I had passed the English Matriculation Examination in Belfast where I had been a student, allowed me to register in the Faculty of Arts and Science. In the following year I registered in the School of Medicine. By 1915, the Arts Building had been constructed and most of the teaching in the first year of Medicine was carried out in it. The subjects taught were, I recall, Physics, Inorganic and Organic Chemistry, Botany and Zoology, French and German. The teachers of those pioneer days were a dedicated group who carried a heavy load with few assistants. Graduate students did not exist. Among the group who taught in first year Medicine were R.W. Boyle in Physics who later distinguished himself in the field of ultrasonics in submarine detection, A.F.L. Lehman, a gifted teacher in Chemistry and J.B. Collip, a youthful and enthusiastic teacher in Zoology.

The second year of Medicine was devoted to the teaching of the basic sciences Anatomy, Physiology, Biochemistry and Bacteriology. As expected the classes in a new medical school in a pioneer province were small, about 20. One wonders, looking back, how the program was carried out with so few teachers. There were actually only two full-time: J.B. Collip taught Physiology, Biochemistry and Pharmacology, D.G. Revell taught gross and microscopic anatomy. It was indeed a privilege to have known both these dedicated teachers. Following the completion of third year medicine, I lost touch, for several years, with medical education in Alberta. The Medical Building was completed in 1922 which gave added teaching space for the basic sciences.

In the early 1920's the Rockefeller Foundation gave a grant of a half million dollars to help the University of Alberta establish clinical teaching and the establishment of a complete program in undergraduate medical education. This program was begun in 1923, ten years after the beginning of the Medical School as a three year school. From 1913 to 1923 about 150 students had participated in the Alberta program and were admitted to McGill, Toronto and Manitoba for the completion of their course.

There were three clinical professorships established in 1923:

Dr. Egerton L. Pope in Medicine

Dr. Frank H. Mewburn in Surgery and

Dr. Leighton C. Conn in Obstetrics and Gynecology.

Dr. Pope was a McGill graduate who received his graduate training in Medicine in London. He was a meticulous clinician and excellent teacher who followed the Oslerian tradition in teaching and practice. I had the privilege of being associated with Dr. Pope in the Student Health Service and the Department of Medicine from 1923 up to his retirement in 1944 and

succeeded him on the latter date as Professor of Medicine. My association with the Faculty of Medicine as a teacher began in 1923 as a lecturer in the Department of Biochemistry. In the summer of that year the Department of Medicine, which was headed by Dr. Heber C. Jamieson, put on a three day course on the clinical use of insulin which had been discovered two years earlier.

Associated with Dr. Jamieson in giving this course was Dr. J.B. Collip who was professor of biochemistry and had recently returned from Toronto where he had made a major contribution in purifying Banting's crude pancreatic extract making insulin available for clinical use. I had the opportunity of meeting Dr. Collip during this course and told him of my plan of shortly going to England for a two year program of graduate training in Internal Medicine. Dr. Collip suggested that a year spent with him in the Department of Biochemistry would be a good basis for Internal Medicine. I agreed to accept this opportunity. Dr. Collip suggested that we should go and see President Tory which we promptly did.

These were the early days in Alberta when decisions were made with directness. Dr. Tory, hearing of my plans, agreed and offered me an appointment as lecturer in biochemistry. He indicated that a Department of Medicine with a full-time Professor would soon be established and that following my year with Dr. Collip and two years of graduate training in Medicine, I might be considered for a part-time appointment with Dr. Pope. Dr. Tory stated that the new Professor of Medicine would be appointed as Director of the Student Health Service and that I might act as resident physician to the University and be available for examining all incoming new students and hold a student sick parade daily and visit sick students in their lodgings for an honorarium of $400 per year to supplement my modest salary as a lecturer in biochemistry.

In these days, 56 years later, these appointments and the salary seem trivial. However, these events played a very significant role in shaping my destiny and academic career.

The one year I had planned on staying with Dr. Collip stretched out to 5 years at Alberta and a year at McGill. Dr. Collip was a keen investigator with a brilliant mind and a friendly interest in those who worked with him. His primary interest was research and I quickly found that I was expected to do most of the undergraduate teaching poorly fitted as I was. I managed to spend some of the summer months at the University of Chicago in the Department of Biochemistry as a graduate student. I should mention that my association with Dr. Pope gave me a valuable training in Internal Medicine.

When Dr. Collip left Alberta in 1927 to take the Chair in Biochemistry at McGill, he invited me to go with him as assistant professor. I declined and made plans to go to London. President Tory asked me to come to his office as I was about to leave and told me that the University was unable to find a suitable successor to Dr. Collip and asked me to carry on as acting head of the Department for a year which I did, with one graduate student. Finally, I did get settled down to a graduate program in London when a wire arrived from Dr. Collip who was then in Montreal telling me that Dr. Bliss, the Associate Professor of Biochemistry at McGill had been appointed to the Chair at Tulane. Could I come to McGill for one session and take over some of the teaching in Biochemistry? I was reluctant to interrupt my program in London and declined Dr. Collip's offer. However, in response to a second telegram, in deference to my teacher and former chief whom I held in high regard, I "pulled up stakes" in London and moved with my family to McGill. I found this to be a valuable year in an active

research department in which, despite a heavy load of teaching, I was able to carry out some research under Professor Babkin. At the end of the academic year Dean Martin and Professor Collip offered me an associated Professorship in the Department. I felt however that my field of interest was Internal Medicine and sent my family back to Edmonton and returned to complete my program in London. On my return to Edmonton I was appointed lecturer in Internal Medicine on a half-time basis under Professor Pope.

I would like to comment briefly on the development of laboratory services in the Department of Medicine. During my undergraduate student days at the University of Alberta, at Glasgow University, (where I spent six months in 1919 awaiting demobilization from the Canadian Army) and at McGill, laboratory tests were few. As I recall, apart from bacteriological tests, a routine urinalysis and blood count were the only ones done.

With the introduction of microscopic methods in blood analysis in the early twenties by Folin and Benedict among others, biochemical procedures were introduced and rapidly developed. For many years the Department of Biochemistry carried out the clinical biochemistry for the University Hospital. My first appointment on the University Hospital staff was as "Honorary Assistant Biochemist" in 1924. All specimens from the Hospital were sent to the Department of Biochemistry where one had to supervise or do the laboratory procedures. In the late 1920's when I was acting head of the Department, I protested to President Wallace. Things moved slowly in those days. It was not until many years later that a clinical services wing was built and Dr. R.E. Bell was appointed Director of Laboratory Services.

The thirties were a dismal period in Alberta with the Provincial Government defaulting on its bonds and the cutting back of the Faculty of

Medicine's operating budget to $60,000 in 1934 with ruthless reduction of staff salaries and honoraria with a partial payment in "Social Credit Script" and the drying up of research funds.

The student registration in all faculties diminished. The graduating class in Medicine diminished to 15 students in 1933.

However, youth is a great asset and one looks back on those years, 50 years later, as having some compensations. Professor Pope as head of Internal Medicine stimulated ones interest as a teacher. If there was little money, there were still sick people and medical students to be taught. One can recall carrying on out-patient clinics attended by students for two full days a week in the McLeod House on the present site of the CNR station. The staff of the Department of Internal Medicine was an enthusiastic group who apart from Dr. Pope were all part-time teachers. Dr. Heber Jamieson was an enthusiast with an interest in diabetes and metabolism. Dr. Charles Hulburt was the first Cardiologist in Alberta. Dr. Walter Scott was interested in chest disease. Dr. Irving Bell taught Therapeutics. The clinical teaching in Medicine was done for the most part at the University Hospital which had only 80 beds. The D.V.A. Hospital for veterans provided further clinical material as did the Royal Alexandra Hospital.

In the early days of clinical teaching the Departments of Pediatrics and Psychiatry and Preventive Medicine existed under the Department of Medicine for administrative purposes. In the early fifties they were established as separate departments with Dr. D.B. Leitch appointed as Professor of Pediatrics, Dr. Spaner as head of Psychiatry and Dr. Stanley Greenhill as Professor of Preventive Medicine.

The program of graduate training as now set out by the Royal College was still many years away. Residents and interns were few. Dr. R.K. Thomson and Dr. Keith Maclean were residents in Medicine when I joined the Department in the 1930's. The first program of undergraduate teaching in medicine lasted six years with the final year as an undergraduate internship.

In the late thirties, the economic clouds in Alberta began to lift. Medicine student enrollment had increased and the graduating class had increased from 15 in 1933 to 35 in 1940. The Second World War attracted a number of the teaching staff to military service. The urgent need for medical officers in the Navy, Army and Air Force led to the enlisting of all physically fit students in the Army, the lengthening of the teaching year to eleven months and the shortening of the junior intern year to 9 months. After this period of training for three years and the conferring of an M.D. degree, all medical students were required to serve in the Armed Forces with the rank of lieutenant. This program increased the teaching load of all teachers in the Faculty of Medicine, some teaching up to 20 hours a week for the 11 month session. We were fortunate in having Canadian and U.S. service units stationed in Edmonton whose medical officers kindly volunteered their services as clinical teachers. Dr. Donald R. Wilson who was a medical officer with the RCAF gave valuable service in the Department of Medicine.

In 1943, the Canadian Department of Defense recognized the possibility that the Canadian Armed Forces might have to serve in tropical areas such as the South Pacific in which they would be exposed to tropical diseases such as malaria and dysentery. As Canadian Medical officers had little knowledge or experience with tropical diseases it was decided that training

in tropical Medicine should be offered as a part of the undergraduate course. Dr. R.M. Shaw and I were selected to attend the Army Medical School in Washington or the Tulane School of Tropical Medicine in New Orleans for a two month intensive period of training in tropical medicine to be followed by two months of hospital experience in Central America. On completion of this program, Dr. Shaw and I put on a lecture and laboratory course in third year medicine for several years.

The end of World War II was followed by the discharge of many medical officers who had entered the Armed Services following a year of internship. Many of these who were Alberta graduates wished to pursue a program of graduate training leading to a specialty but because of similar requests from graduates of eastern Canadian and American Medical Centers no places were available for Alberta medical graduates. Dr. J.J. Ower who was then Dean met with Dr. M.R. Marshall and me at Dr. Ower's home one evening where we discussed the situation. It was decided to set up our own program of clinical graduate training under the direction of Dr. Marshall. The Royal College had outlined by then programs of training to be followed before qualifying to sit for the examinations for Certification and Fellowship in the various specialties. Over the next few years Dr. Marshall directed this graduate training program with vigor in the various clinical specialties in hospitals approved by the Royal College. This was the beginning of clinical graduate training in Alberta.

Research in the Department of Medicine and other clinical departments in a pioneer school, was slow to develop. In the early 1940's the budget for medical research of the National Research Council was less than a half million dollars a year. Later, with an expanding budget and the establishment of a Western Regional Division of the National Research Council,

interest was stimulated in medical research in basic science and clinical departments in our faculty.

In these days of affluence in Alberta it may be difficult to realize that Alberta was at one time a "have not" Province. This "have-notness" in the Provincial economy extended to the University and its Faculty of Medicine. The University of Alberta at one time, in my memory, had the unenviable reputation of paying the lowest salaries in Canada.

I recall when I became Dean of the Faculty in 1948, on a scrutiny of departmental budgets, finding, to my chagrin, that heads and chairmen of basic science departments were paid a maximum salary of $4500 per year with no provision for increment. This level of salary applied to such men as Ralph Shaner in Anatomy, Ardrey Downs in Physiology and Robert Shaw in Bacteriology. Dr. Bert Rawlinson and I interviewed President Newton and told him we thought this was disgraceful. Dr. Newton was sympathetic and suggested we might state our case to the Board of Governors which we did. Dr. Earle Scarlett an internist from Calgary who was Chancellor of the University supported our viewpoint. Mr. Justice Parlee, Chairman of the Board asked us to state a figure. We indicated that these salaries should be doubled which to the credit of the Board took effect in two years. One should mention that within that period the Leduc Oilfield had a number of producing wells. The Provincial Government was not interested in providing money for medical research. Dr. Angus McGugan, superintendent of the University Hospital in the 1950's was instrumental in having the hospital board set aside a small sum of $50,000 named "Special Service Fund" to be used for getting research projects "off the ground" in hopes that the NRC would support them. The fund was later increased and provided some stimulus to research. In these days when we hear of a Heritage Medical Research

Fund of 300 million dollars for the Medical Faculty, we stand in awe and expect great things. One must pay tribute to the late Dean Walter C. McKenzie for his dynamic leadership during his tenure of fifteen years as Dean of the Faculty of Medicine in the expansion of the medical school both in teaching and research in all departments.

I enjoyed all of my 36 years as a member of the staff of the University of Alberta. The individuals who stand out most in my memory as colleagues are: Dr. H.C. Jamieson, the first internist in Edmonton who befriended me immeasurably in my early days of practice, Dr. J.F. Elliott a true Oslerian physician and teacher whom I had the privilege of being associated with in practice from 1945 to 1979, J.B. Collip as a personal friend and advisor and a great scientist to whom I owe a great deal, E.L. Pope, a master clinician who taught me many basic things in Internal Medicine, H.E. Rawlinson, a gifted and articulate scholar who as Assistant Dean gave me the benefit of his wisdom and guidance, A.C. Rankin, the first Dean of the Faculty who always showed wisdom and restraint and the hallmarks of a gentleman. He will always stand out in my memory as "The Dean". J.J. Ower, who preceded me as Dean had a buoyancy of spirit and humor that helped him to bear "the slings and arrows of outrageous fortune" of which he had more than his share.

The period I enjoyed most was in the 1930's as a junior member of the staff of the Department of Medicine. Classes were small. One knew all the students on a first name basis. The teaching of medicine was done for the most part in small bedside groups. However, one teaching exercise I recall was the so called combined clinics of third and fourth year students held for two hours on alternate Thursday mornings in the Mewburn Auditorium. In the two years that students attended these combined clinics they had an

opportunity to see patients presented by their fellow students covering a fair spectrum of Medicine. The cases were discussed by members of the teaching staff in Medicine, Anatomy, Physiology, Biochemistry and Pathology. An attempt was made to co-relate the basic sciences with clinical medicine.

In looking back over nearly 50 years one should mention that changes in the pattern of disease which presents itself for teaching. When I began teaching in the thirties, typhoid fever was common as was tertiary syphilis. Indeed, Dr. Pope devoted ten lectures of his introductory course in clinical medicine to these two diseases and used to quote Osler's axiom "If you know typhoid and syphilis in all their manifestations, all things clinical will be added unto you". Patients with tabes, general paresis, meningo-vascular syphilis, aortic aneurysm, syphilitic aortitis and aortic incompetence were common. Before the days of compulsory pateurization of milk, brucelloses was always with us. Tularemia occurred in the days of skinning and feeding of rabbits to domestically raised fur bearing animals. One recalls that Robert Macbeth and I published a paper on ten such cases who were patients in the University Hospital, three of whom died of the disease. Before the days of Salk and Sabin vaccine, poliomyelitis was a common and dread disease in the hospital wards. The last major epidemic of this disease occurred in Edmonton in 1953 and attacked many adults including the late Dr. R.E. Bell, one time Director of Clinical Laboratory Services in the University Hospital. A special unit was set up in the Royal Alexandra Hospital for the respiratory cases. The members of our Department of Medicine among others gave generously of their time on a round the clock voluntary basis in providing medical services to these patients.

Over the years the natural history of some diseases has changed. Scarlet fever was at one time a common and occasionally fatal disease. A severe epidemic of scarlet fever in the thirties affected a great number of University students in the residences. The outbreak was severe enough that in my capacity as Director of Student Health Service, I, in consultation with the provincial and city departments of health, advised President Kerr to close down the University which was done for a three week period.

Looking back over a period of 65 years since I first became interested in Medicine it is fascinating to recall the events I have seen. I have watched the development of the Faculty of Medicine from its creation to its becoming a leader in undergraduate and graduate teaching and research in Canada. It is exciting to recall the major milestones in the investigation and treatment of sick people that have occurred in my medical lifetime. Among them the introduction and use of insulin in the early twenties, the use of liver in the treatment of pernicious anemia in 1925, the use of sulphonamides in the early thirties soon to be followed by the use of antibiotics. The isolation of adrenal cortical hormones and radio-active isotopes and the concept of immunity in disease have revolutioned our concepts of internal medicine.

May I reminisce about one or two personal experiences. Dean Rankin asked me to come to his office in 1944 and told me I had been appointed Professor of Medicine. Dr. J.J. Ower who occupied an adjoining office congratulated me and in his whimsical way told me my first task should be to help select my successor. I took Dr. Ower very seriously and in a year or two made a trip to Boston to talk to Dr. Donald Wilson in the hope of interesting him and his wife Ruth in coming to live in Alberta. Fortunately for Alberta, I was successful. Dr. Wilson who had attained senior rank

as a medical officer in the RCAF came to Edmonton on the completion of his graduate training at the Massachusetts General Hospital. He shortly afterwards won a Nuffield Fellowship and began a distinguished career in the Department of Medicine succeeding me in 1954. It is gratifying that Dr. Wilson, Dr. Fraser, Dr. Sproule and Dr. Molnar who have so efficiently acted as Professors of Medicine were at one time Alberta students.

My visit to Boston also was in other ways a rewarding experience in enabling me to meet or hear some of the giants of the golden age of Boston medicine. Among them were Dr. Howard Means and Dr. Fuller Albright of the Massachusetts General Hospital. I recall an interesting conference at the Peter Bent Brigham Hospital presided over by Dr. George Thorn. On this occasion there was featured an anniversary of the use of liver therapy in pernicious anaemia. A number of the original patients of Dr. Minot who received this therapy were presented and discussed by Dr. Minot, Dr. Murphy, Dr. Castle, Dr. Dameschek and Dr. Diamond — an outstanding galaxy of hematologists.

May I revert to the early days of the Faculty of Medicine in Alberta? As often happens when a closed teaching hospital exists in a community, a "town and gown" relationship among the medical practitioners tends to exist which today has, I hope, disappeared. I would like to mention two agencies that helped to dispel it. The Edmonton Academy of Medicine which existed long before the establishment of the medical school was an organization to which most Edmonton doctors belonged. I was privileged in being a member of the council for several years and its president. The Academy did a good deal to create understanding and good fellowship between the University and non-University practitioners. Another, perhaps fleeting factor, was the organization of "Journal Clubs" by Dr. J.J. Ower. In organizing these

clubs, Dr. Ower astutely selected groups of University and non-University Hospital doctors. The groups met monthly for dinner following which members reported medical journal articles for discussion. There were a number of such groups which created a mix of doctors that served a useful purpose.

A medical school one feels, should exist, not only as an agency for furthering undergraduate and graduate teaching and medical research but also to lend support to organized medicine at the municipal, provincial, national and international levels. The Department of Medicine, as have other Departments in our medical school, has striven to do this. I have already mentioned the Edmonton Academy of Medicine at the municipal level. The Alberta Medical Association has had a close liaison with the medical school and one of its officers has for many years been a member of the Medical Faculty Council. Two of the members of the Department of Medicine, Dr. Harold Orr and Dr. R.K. Thomson have been presidents of the Canadian Medical Association.

The Association of Canadian Medical Colleges was established in the 1940's as a forum at which the Deans and other officers of Canadian Medical Schools could discuss matters of common interest. Originally the American Association was the meeting place. The Canadian group met annually with a part-time secretary and no permanent office. During my tenure as President, I made an attempt through the Commonwealth Fund and the Rockefeller Foundation to obtain funds to upgrade the Association, expand its activities and employ a permanent secretary. I met with failure in my attempt. A few years later Dr. Joe McFarlane, Dean of Medicine of the University of Toronto, called a meeting of the Association together with representatives of the Royal College and the Division of Medical Education of the C.M.A.

Here was hammered out the terms of agreement and financial support for the Association which has greatly expanded its activities since. The first permanent secretary was Dr. Wendell McLeod formerly Dean of Medicine at the University of Saskatchewan.

I would like to mention another national organization in which I was interested, the National Research Council. This was founded by Dr. H.M. Tory, the first President of the University of Alberta, in the mid-twenties without any interest in medical research. In the 1930's advisory committees in various fields of research were formed. The one in Medicine was first chaired by Sir Frederick Banting with Dr. Chester Steward, Dean of Medicine at Dalhousie, as secretary. Sir Frederick and Dr. Stewart visited our Faculty of Medicine in the mid-thirties in an effort to stimulate medical research in Alberta. Following Banting's untimely death, Dr. Collip was appointed Chairman of the Medical Advisory Committee with Dr. Ettinger, Dean of Medicine at Queens University, as secretary. I served on this Committee for a number of post-war years which was an interesting experience. The amount allocated for medical research in Canada under this Committee when I joined it was, I recall, $350,000. Fortunately, it was increased dramatically following "Sputnik" when the Canadian government became more research conscious. Shortly after this the Medical Research Council was set up as a separate entity under the presidency of Dr. Collip to be followed by Dr. Ray Farquharson and Dr. Malcolm Brown. The budget now is over 50 million dollars. I referred earlier to the fact that the NRC made a small grant to establish Western Regional meetings at the four Western Medical Schools. Dr. Thorlakson of Winnipeg and I played a part in this project which encouraged medical research in Alberta, British Columbia, Saskatchewan and Manitoba.

Another national organization in which I was interested in my active days was the Royal College of Physicians and Surgeons of Canada. The College was founded in 1929 by a small group who shortly afterward asked me to join it as a Charter Fellow. It was a fascinating experience to see the development of this organization over the past 50 years from a small group of a few hundred to over twenty-six thousand fellows. Our Faculty of Medicine has contributed greatly over the years to the development and functioning of the Royal College. Dr. E.L. Pope was one of the first Vice-Presidents. Dr. W.F. Gillespie and Dr. W.C. MacKenzie were Presidents. Dr. Donald R. Wilson of the Department of Medicine made a monumental contribution as Chairman of the R.S. McLaughlin Research Centre in studying and advising the College on methods of examinations. Initially, the annual meetings in Ottawa were attended by a few of the fellows. We had dinner together and discussed College business. Dr. Ray Farquharson and Dr. Fulton Gillespie at one of these meetings in the early thirties suggested it would be interesting to have a short scientific program following dinner. The program has expanded to three or four days and provides a forum for the best of Canadian medicine. I had the privilege of being associated with the College from its beginning, serving on many of its Committees and acting as College examiner at both the Certification and Fellowship levels. However, the most interesting memories I have are the 8 or 10 years I served on Council and as President of the College from 1959 to 1961. At the Vancouver meeting in 1961 I had the pleasure of admitting my son, Foster, to the fellowship.

One would like to name another organization which has made a fine contribution to Canadian Medicine, the American College of Physicians. I enjoyed serving on its Board of Governors for 9 years and the privilege of

being a fellow and master of the College. The two outstanding contributions apart from the annual meetings, which I recall, were the regional meetings of the College and the graduate courses. Dr. Allan Edwards, a member of the Department of Medicine who served for many years as a College Governor was instrumental in arranging many of the regional meetings in Western Canada. Some of these meetings were held jointly with the Royal College and included members of our Department of Medicine as speakers.

"Thus ends this common-place and uneventful history"

J.W. Scott

HISTORY OF THE DEPARTMENT OF MEDICINE

DR. D.R. WILSON

PROFESSOR AND CHAIRMAN

DEPARTMENT OF MEDICINE

1954 - 1969

Preamble

My stewardship as Chairman of the Department of Medicine probably had its beginnings (at least in part) as far back as 1933 when, of all people, Daddy Revell, who was then Chairman of the Department of Anatomy, called me into his office and, very directly and without beating about the bush, asked the question "Why don't you apply for a Rhodes scholarship?" It was something that had never crossed my mind up to this point, but on further enquiry to two Rhodes scholars, Dr. George Smith, the Head of the Department of History, and Dr. Ken Hamilton, who was on staff at the University Hospital, I decided that no harm could come from applying for it.

My trouble began in 1935, after I had been awarded the scholarship and started to apply for colleges. I found that very few people knew anything about Oxford at the time, including Ken Hamilton, because he hadn't been there for some years. When I arrived in Oxford I found that the Medical School would not recognize any of the four years of Medicine that I had taken at the University of Alberta, so I was then faced with the prospect of repeating the whole four years or launching off into a Doctor of Philosophy Program, but I found that I could not do this because I did not have an undergraduate degree. I therefore attempted in my first term at Oxford to cover all of the ground that I had covered in the last four years hoping to write the exams, but found this to be an impossible task, so that the first three months at Oxford were a complete waste of academic time. I then chose the only remaining option; that was to take an honors degree in the Department of Physiology. On completing my training in Physiology and receiving my degree in 1937, I returned to Canada and completed my medical training in 1939 at McGill University.

My first inkling as to any possibility of becoming the Chairman of the Department of Medicine occurred in 1943 when I happened to run into Dr. John Scott on Confederation Square in Ottawa, when I was in the Royal Canadian Air Force. During our conversation there, on a chilly fall day, he intimated that he had been talking to Dr. Johnny Ower and they had decided (other things being equal) that I should return to the University of Alberta and, because of my background of two years training in Clinical Physiology, they felt that, other things being equal, I had a very good prospect of becoming the chairman of the Department on Dr. Scott's retirement.

I returned to the University after some five years in the Air Force in 1947, and from 1949 onwards as a Markle scholar, began to develop an Endocrine Laboratory which, in those days, was a rather simple affair, consisting of developing techniques for the measurement of FSH, 17-ketosteroids, and a rather complicated method for measuring urinary corticoids. The laboratory, at that time, was located in a little room behind the elevator shaft in the old 1912 wing, and with the assistance of Miss Mary Beth Saunders, I was able to get these techniques started by the end of 1949.

In order to keep the chronology straight, the years between 1947 and 1949 were spent as a part-time teacher, during which time I devoted a major portion of my time to clinical teaching, spending two or three afternoons a week downtown in Dr. Heber Jamieson's office, who was then on his way into retirement.

I'll never forget the first day in office as Chairman of the Department when Dr. Scott showed me the budget for the Department of Medicine. It should be noted at that time that the Department of Medicine also included what ultimately became the Departments of Psychiatry, Pediatrics,

Preventive Medicine and Public Health and, finally, Physical Medicine and Rehabilitation. The total budget for all of those areas at that time was $10,000 a year, which also included Dr. John Scott's salary as Head of the Department and Dean of the Faculty, which amounted to $4,000 a year. Another note that may be of interest is that the total research budget for the whole faculty at that time was under $10,000 a year. Such was the clinical and research picture in the year 1954 when the entire clinical teaching was done by part-time staff.

I can remember wondering at that time how the clinical staff carried the teaching burden during the war years, because there were so few of them. After the conclusion of the Second World War, these oldtimers welcomed the people returning from the Armed Forces with open arms. I can well remember Dr. John Scott saying that his teaching load during the war years was twenty hours a week!

There was a Clinical Investigation Unit of the Royal Canadian Air Force stationed in what is now Corbett Hall and because we weren't particularly busy at that time, we helped out with clinical teaching during the years from 1942 onward. I lost track of this R.C.A.F. station contribution to the teaching program at the University Hospital when I was posted to Air Force Headquarters late in the fall of that year, but I know that it did carry on for a few years afterwards.

1954 - 1969

When I took office as Chairman of the Department, I became the first geographic full-time member of the staff, along with Dr. Bob Fraser, who was then on a medical scholarship program. Believe you me, we were very lonesome people, for whom the part-time staff had no particular love or

affection. One very powerful member of the part-time staff, who shall go unnamed, told me quite frankly that he would make it his own personal business to see that the concept of geographic full-time positions in the Faculty was destroyed. Fortunately, this never came to pass.

In 1954, the total teaching staff in Medicine, Pediatrics, Psychiatry, Preventive Medicine and Public Health, and Rehabilitation consisted of 19 staff members at the University Hospital. Of that group, there are still some active in practice and teaching - Dr. Gordon Bell, Dr. Frank Elliott, Dr. Allan Gilbert, Dr. H.B. Armstrong, Dr. L.C. Grisdale, Dr. T.A. Gander and Dr. Louis Beauchamp. The Department of Psychiatry at that time consisted of one person, Dr. Sid Spanner who, unfortunately, is no longer with us. Dr. Ken Thompson, although no longer directly associated with the teaching staff of the University Hospital, is still very active in medical affairs in the Province.

In that particular year, in looking at the annual reports, I find that the total teaching staff in the clinical departments which I have referred to above, for all of the hospitals involved in the teaching program, was some 32 members. It is also interesting to note that the first two subspecialty units which ultimately became Divisions of the Department of Medicine, came into being. They were the Cardiovascular Unit under the direction of Dr. R.S. Fraser, and the Endocrinology Laboratory which has also been mentioned above. Dr. Brian Sproule, who was then a member of the resident staff, was awarded a special scholarship to enable him to assist Dr. Fraser in the development of the Cardiovascular Unit. It was during that time that Dr. Sproule developed a special interest in the pulmonary aspects of cardiovascular disease and he subsequently went on to graduate training in the United States, later returning to the staff. During that

year, as President of the Medical Staff, there is a note in the annual report which brings back many memories of the very serious polio epidemic of the preceding year, 1953. In the year 1954, what is now Station 32, was totally turned over to the care of the respiratory polio patients which greatly reduced a number of teaching beds in the Department of Medicine. This was a major task which was undertaken during that year, namely the transport of these respirator cases from the old Infectious Disease Hospital on the grounds of the Royal Alexandra Hospital site to Station 32. Another point that is also of interest is that Miss Marny McKay, who was in charge of the Unit, subsequently married Dr. Brian Sproule.

I think it could fairly be said that from the early '30s when I was a medical student to about 1954, the Department and its facilities remained relatively static, reflecting the fact that money was not available during the depression and the "dirty '30s" and then, during the War, the major effort was devoted towards turning out physicians with what facilities did exist. From 1954 on, with the return of physicians from the War and from postwar training programs, and with prosperity just beginning to make its appearance, particularly in the West, with the discovery of oil at Leduc. The period from 1954 to 1969, fortunately, from my point of view, could be called the period of rapid expansion. About 1968 or 1969, it gradually became evident that the Government was beginning to progressively turn off the money flow to universities, and the Faculty of Medicine suffered, as well as the rest of the University.

In 1955, there was an increased expansion of the Cardiovascular Unit, in as much as Bob Fraser followed me as Chairman of the Department of Medicine, his recollections of the development of the Unit will be much more accurate than mine. During the year, the use of radioisotopes first

made its appearance in the University Hospital, with the introduction of radioactive iodine as a diagnostic and therapeutic tool. In the light of the present day's state of the resident staff and resident training program, it is interesting to note that during the year Dr. Adam Little became the last appointed resident in the Department of Medicine. He arrived from New York, in January, and this brought the total to 6, which, at that time, was thought to be a new level of achievement in so far as the number of house staff was concerned.

In 1956, with return of Dr. Brian Sproule from the United States, the recruitment of Dr. George Monckton in the field of Neurology, and the addition of Dr. R.E. Rossall to the Cardiovascular Unit, the diagnostic and research facilities in these three areas became well established and added greatly to the clinical and research activities within the Department. It was also, I think, during this year, that the Special Services Committee was established which had, at its disposal, revenue derived from funds which had been accumulated under the shrewd management of Dr. A.C. McGugan, and this created greatly increased activity in the field of clinical investigation.

It is interesting to note in the hospital report of that year that the University Hospital had received accreditation from the Royal College of Physicians and Surgeons for the teaching of postgraduate students. This was the last year in which individual hospitals were approved for postgraduate training. From that point on, university programs as a whole were approved by the Royal College, and this approval or nonapproval embraced the total network of teaching hospitals in any given university.

It is also interesting to note, by this time, that many of the clinical areas which were Divisions of the Department of Medicine had begun to

split off and become separate departments in their own right. The first to become a separate department was Pediatrics, followed shortly thereafter, in the same year, by the creation of the Department of Psychiatry. At this time, it should be mentioned that the Department of Psychiatry had the magnificent total of two psychiatrists on staff to service the needs of a 1,200 bed hospital because it was during that particular year that the last of the clinical service wings was completed, which has always been referred to since as the "1956 Wing". This Wing of the Hospital was designed primarily to provide space for Rehabilitation Medicine and Pediatrics, but, in addition, provided space for Orthopedics, Cardiovascular Surgery, and Eye, Ear, Nose and Throat patients.

By 1957, the Cardiovascular Unit had become sufficiently well developed to permit the opening of the first Open Heart Unit in Canada, Dr. John Callaghan being the first appointee on the surgical side in the preceding year. During the year, the geographic, full-time concept had spread to include Pediatrics, Psychiatry, Clinical Laboratories, and Rehabilitation Medicine, and in several of these Departments, in addition to the Heads being geographic or full-time, there were several Divisional Heads who had also taken up geographic full-time positions. Many new clinics became organized in the Outpatient Department. The admission of patients from these areas had doubled from the previous year, providing a much greater variety of clinical teaching material. By this time, postgraduate clinical investigation had become well developed, and since the year 1954, the Department of Medicine had at least one postgraduate student pursuing clinical research towards an M.Sc. degree. In 1956, there were two.

During 1958, continued expansion was the order of the day, with the addition of three, new geographic full-time appointees, and the development

of a more comprehensive continuing medical education program. Again, two fellows completed the requirements for M.Sc. degrees in the fields of clinical research, and it is interesting to note that research funds in the Department of Medicine alone were almost seven times that of the total Medical School when I first returned from the war in 1947. During the year 1958, some $67,000 was available for research.

In 1959, there was continued expansion of the Division of Pulmonary Medicine, the Cardiovascular Division, and the Division of Endocrinology. With the addition of Dr. Gordon Brown to the staff, the first full-fledged teaching program for diabetic patients was established and we were able to obtain the full-time services of a teaching nurse, Miss Ruth Shaw. Mr. and Mrs. Muttart who, over the years, have given generously to the Faculty of Medicine and the University Hospital, established a diabetic reference library, and, as I read this, I think it should be recorded that Mr. and Mrs. Muttart and subsequent to their death, the Muttart Foundation, have given to the Faculty of Medicine, (predominantly to the Department of Medicine) funds well in excess of $1,000,000 and for this the Faculty and the Department will be eternally grateful for provision of assistance of this magnitude when it was most needed.

1959 witnessed the return of the Outpatient Department to the University Hospital itself. In previous years, the Outpatient Department had been located in the Alberta Building, (which was in the downtown area), just east of the MacDonald Hotel, where it had functioned during the war years and subsequent to that. There had been some concern that the movement of the Clinic to the Hospital would result in a decline in numbers, but this was subsequently proven not to be the case. In the field of graduate training, formalized programs were developed and 1959 witnessed

the second year of this full five year training program leading to fellowship in the Royal College of Physicians and Surgeons of Canada.

The first year of the 1960's witnessed the retirement of Dr. A.C. McGugan who had served eighteen years as Superintendant of the Hospital and coincident on this, the appointment of the first nonmedical Administrator of the Hospital, in the person of Mr. R. Adshead, who had previously served as the Business Administrator of the Hospital. He had been associated with the Hospital from his early teens. There is an interesting note from the Hospital point of view, the new Executive Director of the Hospital, Dr. J.D. Wallace, (succeeding Mr. Adshead) expressed his concern over the rising cost of operating clinical facilities in the Hospital when he noted that it had been necessary to increase the day rate from $18.97 a day to $20.64 a day. Little did he realize at that time what would take place in the field of hospital costs in the ensuing twenty years. In the Department of Medicine, the introduction of the artificial kidney was, I think, the major note of interest during that particular year. Its introduction was the result of increasing interest on the part of Dr. Lionel McLeod in this new lifesaving device in the field of renal disease. At the undergraduate level, for the first time, medical students were introduced to the concept of "living in" wherein they began to function as clinical clerks or, for all practical purposes, junior interns. The same problems continued to beset the Department that had been noted in previous years, that is, that of increasing demands for services at both outpatient and inpatient levels.

1962 witnessed the completion of the renovation program of the old 1912 portion of the Hospital and the completion of new facilities in the South wing of the Hospital. The Department was reorganized into a series of Divisions each operating within the geographic confines of their own

respective wards. Increased collaboration between the Division of Cardiology and the Pulmonary Division resulted in increased quality of care and research in the field of cardiopulmonary disease and also in the pre- and postoperative care of patients coming to the hospital for open heart surgery. In the field of Endocrinology, as a result of Dr. David Fawcett's work, the quality of commercially available radioactive iodine was considerably enhanced. This was a real contribution to the utilization of radioactive iodine right across Canada. A new division was added to the Department in the creation of a Division of Clinical Pharmacology, working closely with the Department of Pharmacology to test out the clinical effects of new drugs as they appeared on the market. With the development of the new ward system where patients with similar diseases were concentrated into geographic areas of the hospital, there was a marked improvement in the quality of care of patients, but it did pose problems from the standpoint of undergraduate teaching, which had to be solved. However, with the introduction of the ward system, one of the unforeseen benefits was a significant shortening in the length of stay of patients in hospital. The ward system also made possible the creation of comparable outpatient clinics so that patients seen in any particular division returned to a divisional outpatient clinic, which made possible long term care of patients under the same clinical staff.

1963 witnessed the first introduction of cardiac pacemakers. The year 1963 witnessed the first complete year of operation of the Metabolic Unit, wherein patients with metabolic disease were able to be studied intensively in a separate unit of the hospital. The activities of this unit (initiated in 1949) were closely integrated with the artificial kidney program, resulting in accumulation of much valuable research data.

In 1964, with the completion of the renovation program, it was possible to add one new clinic in General Medicine to the Outpatient Department, which, in addition to being a valuable unit from the standpoint of treatment of patients, was also equally valuable in teaching at all levels of the undergraduate and postgraduate medical training. A Division of Gastroenterology was also introduced during the year. Also, during the year, plans were completed for computer recording of data on some 2,600 cardiac patients who had been treated in the Cardiovascular Division. In the Division of Pulmonary Disease, the Inhalation Therapy Unit showed a marked increase in utilization. Both the Divisions of Cardiology and Pulmonary Disease established a very profitable working relationship with the Faculty of Physical Education. Two graduate students in the Division of Pulmonary Disease enrolled in the postgraduate educational program and were proceeding to their degrees in Master of Science, that is, Dr. Philipson and Dr. Patricia Lynne-Davies. The latter of them subsequently joined the staff, Dr. Philipson did not return to Alberta but joined the staff of the Toronto General Hospital, where he has subsequently made important contributions in the field of pulmonary disease. Dr. David Fawcett was awarded a Medical Research Council Scholarship which has permitted him to continue his studies in the field of thyroid disease and, also, it has made it possible for him to develop new and more refined techniques for the measurement of various steroid hormones. These simpler, more reliable techniques have greatly facilitated the clinical work in this particular division of the Department. The Division of Clinical Pharmacology expanded its activities into collaborative studies with the Cardiac Division and the embryo Division of Gastroenterology. The Division also developed collaborative work with the Department of Obstetrics and Gynaecology, studying the effects of

various adrenergic drugs on normal and premature labor situations. With the completion of the renovation program and the constantly increasing demands of the public for highly specialized diagnostic and treatment programs, the Department responded by continuing to add new members to the staff, but, by this time, the staffing situation had reached the point where it could not be expanded further without the addition of further clinical beds in which to house the patients requiring inpatient diagnostic and treatment facilities. During the year, a special cardiac resuscitation team was developed under the direction of Dr. Russell Taylor.

In 1965, the Division of Neurology was fortunate to obtain the services of a well-trained neurological biochemist in the person of Dr. Taiichi Nihei. Dr. Nihei devoted his full time to studying protein chemistry in relation to muscle disease. Collaborative studies between the Divisions of Cardiology and Pulmonary Disease with the Faculty of Physical Education continued to expand, resulting in the bilateral appointment of Dr. Paez as an assistant professor, both in the Faculty of Physical Education and in the Faculty of Medicine. Dr. Joseph Martin, who subsequently became a Centennial Fellow of the M.R.C. in 1967, left our program to complete his training in Neurology in Cleveland. Through a succession of distinguished appointments in the United States and McGill, he subsequently returned to Boston to become Professor of Neurology at the Massachusetts General Hospital of the Harvard Medical School.

The year 1966 was one of feverish planning for the future. Much energy and time of the Department was devoted to the completion of the detailed planning for the Clinical Sciences Building and for preliminary planning for the Centennial Hospital addition. In the Division of Cardiology, even more complex methods for assessing cardiac function were introduced. Geographic techniques for coronary artery visualization were

further refined, which have been of great assistance in selecting appropriate patients for coronary artery surgery. Programs for the computerization of interpretation of electrocardiograms were introduced by Dr. Fraser following his sabbatical year. In the field of endocrinology and metabolism, Dr. Crockford was able to introduce new methods for radioassay measurement of insulin, and, also, new labatory techniques for the measurement of glucagon and growth hormone. With the increasing demands for artificial kidney therapy during the year, it was possible to increase the establishment for professional and technical personnel to deal with these renal problems on a long range basis. During the year, formalization of the Division of Gastroenterology took place. The Royal College of Physicians and Surgeons of Canada made one of its periodic five year reviews, and the Department was gratified to receive the report which indicated that the postgraduate training program was among the best in Canada. This, to a considerable extent, was due, in part, to a growing number of superior applicants applying for training in the program produced by a staff of growing national and international status.

In 1967, the clinical clerkship program was further developed and refined. New methods were introduced for the evaluation of student progress while they were with the Department. Personal counselling of individual students was put into effect, with considerable benefit. The fourth year clinical clerkship program was decentralized to a considerable extent to the affiliated teaching hospitals. In the field of graduate medical education, all former residents who took the examinations of the Royal College were successful and three students enrolled in the Faculty of Graduate Studies for their Master of Science degrees. During the year, an international symposium in the field of renal disease, which developed

largely as a result of the enthusiasm of Dr. L.E. Mcleod, was held on campus. The three day program was attended by a distinguished group of research scientists from all parts of the world. In the field of medical research, it is interesting to note that the budget for the whole Faculty which, in 1954, was somewhat under $10,000 of which Medicine had a small part, had grown to the allocation of research grants of some $250,000 in the centennial year. Also, during the year, because of the increased awareness of the more reliable evaluation of graduate students, the Royal College of Physicians and Surgeons of Canada established the R.S. McLaughlin Research and Examination Centre within the University of Alberta. During that year, I was appointed as the first Director of the Centre which added significantly to my workload of running the Department, as well as attempting to develop this new venture in the evaluation of postgraduate medical education. It would not have been possible to carry this significant increase in workload were it not for the fact that the Department was extremely fortunate in having Mr. J.G. Kerr, a former Air Vice Marshall and Deputy Chief of the Air Staff, as Administrative Officer of the Department. With his administrative capacity and ability, he was able to assume the control and direction of all non-medical administrative activities in the Department. During the year, a Rheumatic Diseases Unit was established at the University Hospital, funded by the Canadian Arthritis and Rheumatism Society, and Dr. J.S. Percy was appointed to head up this new venture. Through the generosity of the Gladys and Merrill Muttart Foundation, it became possible to establish a visiting professorship created to recognize the scientific contributions of Dr. J.B. Collip, most specifically with respect to the role which he played in the discovery of Insulin. Dr. Brian Hudson, the Professor of Medicine from Monash University and a distinguished scientist in his own right, was the first J.B.

Collip visiting professor. During his year of tenure, he greatly stimulated all members of the staff, and specifically added much to the Division of Endocrinology. He was further responsible for the development of computerized techniques for evaluation which subsequently resulted in the introduction of computer-based examinations in the field of pediatrics, the first such venture anywhere in the world. In addition to participating in departmental affairs, at both the undergraduate and graduate levels, he also was able to develop new methods to measure androgens in biological fluids. The Muttart Foundation was also instrumental in providing funds for the purchase of an electron microscope, which made it possible to develop the J.B. Collip Research Laboratory in Neurological Diseases. During the year, three members of the Departmenc held important positions as Presidents of Canadian Societies and Associations; Dr. Ken Thompson completed his term as President of the Canadian Medical Association, Dr. L.E. McLeod was President of the Canadian Society of Nephrology, and Dr. R.S. Fraser was President of the Canadian Cardiovascular Society. Dr. Allan Gilbert was Vice-President of the Canadian Association of Gastroenterology and Dr. D.R. Wilson was Vice-President of the Division of Medicine of the Royal College of Physicians and Surgeons of Canada. A Student Evaluation Board was established and made directly responsible to the Faculty for all undergraduate evaluation; the first such event in Canada and producing, for the first time, fully objective examinations with complete computer storage and retrieval capability, along with complete marking of all written examinations. Complete psychometric analysis of all examinations was made possible with the collaboration with the R.S. McLaughlin Centre.

1969 was the last year of my tenure as Chairman of the Department, and one of the major problems during that year was the very significant physical move from the University of Alberta Hospital to the new Clinical Sciences Building. The requisitioning of new scientific equipment, the detailed planning and installation of the equipment and the phasing of the move of existing laboratories all posed major problems. These were very smoothly and expertly handled by Mr. J.G. Kerr as the Administrative Officer of the Department, working in collaboration with various Divisional Heads. The clinical clerkship program continued to improve. During the year, postgraduate students enrolled in the Faculty of Graduate Studies were successful in obtaining their Master of Science degrees. Ten members of the postgraduate group were successful in their fellowship examinations of the Royal College, and one further member of the postgraduate training plan was successful in his certification. The first international conference of medical education was conducted during the year under the chairmanship of Dr. J.A.L. Gilbert. This conference attracted authorities from many parts of the world, with an attendance of some 150 people. In the field of medical research, grants in excess of $280,000 were obtained by members of the staff. In the Division of Cardiology, major studies were being carried out with respect to the hemodynamic response to exercise before and after open heart surgery, and in the Pulmonary Division, major studies were being developed in chronic obstructive lung disease, bronchitis and emphysema. One of the main problems of the year was the mixing of the old and the new undergraduate curriculae in such a way as to minimize the disruption that would occur as the result of running two programs at the same time. In the Division of Endocrinology, new investigations were commenced into the replication of an RNA virus and the effect of the virus

on host metabolism. New research areas of activity began to appear with the development of plasma Insulin responses to oral and intravenous glucose loads. In the Division of Infectious Disease (which was created with the return of Dr. George Goldsand to the staff), three new studies got underway during the year, with the study of Colicin activity in human serum; secondly, the role of bacterial cell wall variance in human disease; and thirdly, the role cf anaerobic bacteria in infections of the middle and paranasal sinuses. Studies were also launched in the field of tissue rejection with the acquisition of Dr. John Dossetor to the staff. A Transplant Immunology Laboratory was developed in the University Hospital, with the move of several of the Department of Medicine personnel into the Clinical Sciences Building. Dr. Dossetor brought with him several of his staff from McGill University, and, with the arrival of this staff, a new Division of Nephrology is being established. This new venture, in collaboration with Dr. Diener and his group, attracted an M.R.C. grant of $1,250,000 over a five year period.

With the gradually increasing activity of the R.S. McLaughlin Foundation Research Centre, it became necessary to make a choice between directing the newly developed Centre, or continuing on as Chairman of the Department. After fifteen years as Chairman, I decided that it was time to move on into the development of the new Centre, and tendered my resignation as Chairman, effective the end of July, 1969.

In Conclusion

As I dictated this report, a few other thoughts crossed my mind that might be worthwhile recording. In the year preceding my appointment as Chairman of the Department, Dr. John Scott asked me to deputize for him on

the Medical Advisory Board, feeling that a year's experience on the Board would be helpful when I had to take over the reins of office. During this twelve month period, Dr. McGugan, who was then the Medical Superintendant and a rather testy old Scotsman at the time, twice threatened to throw me off the staff of the Hospital. The first clash I had with him was over the application form for appointment to the University Hospital, which required that the applicant declare his religious denomination. I felt that this had nothing to do with staff appointments to the Hospital, I insisted that this be removed. He became so incensed at the insistence of this young upstart that, although he did not physically throw me out of his office, he asked me to leave while he considered whether I should remain on the staff of the Hospital. The next morning, he called me into his office and said that he had thought it over and he felt that perhaps this was a good idea afterall, and that he had no objection to this change. It was subsequent to this change in the staff application forms that Dr. Joe Dvorkin was appointed to the staff of the Department.

The second clash I had with Dr. McGugan was over the building of a private office on University Hospital premises by one of the members of staff (not the Department of Medicine). The whole Medical Advisory Board was so incensed at this development that they recorded their feelings in the minutes. I personally went to see Dr. McGugan about it and, again, although not physically tossed out, was asked to leave forthwith. However, with the passage of time, Dr. McGugan and I gradually became the best of friends, and, in subsequent years, when his physical vigor began to decline somewhat, Swede Gourlay, who was then in the Department of Surgery, and Morris Adamson, who was Head of the Rehabilitation Unit, and I, used to take Dr. McGugan out chicken shooting. He was always insistent on wearing

his double breasted, navy blue, winter overcoat - hence, he stuck out like a sore thumb against the golden autumn background. Swede, Morris and I did most of the walking whilst he reclined leisurely against a large tree. Although, to recall - he shot most of the grouse.

One other memory I have of my years in the Department is that, during the fifteen year period, my office was moved no less than seven times, which indicates the degree of activity that went on in the renovation of the old areas of the Hospital, and the development of new facilities. My first office in the Hospital, which Dr. McGugan felt very proud of, had formally been the University Hospital coalbin when the hospital was heated separately from the rest of the campus. The two rooms which I was allocated were so hot that they were almost beyond human endurance, and I noted, with somewhat pardonable pride, when I made my second move to somewhat cooler quarters, that my original office was converted into a quick-drying room for rubber gloves from the operating room.

I like to think that, during the time I held this position, it was the most interesting and happy period of University and University Hospital life. It was a period of rapid expansion and obtaining funds for new staff members and research equipment consistuted no problem. The main problem, really, was to find the best personnel available to staff the Department. It became obvious in the latter part of 1968 that the screws were gradually being turned down on the University budget, so that, in many ways, I considered myself fortunate to have escaped just at the time that increasing restraints were being placed on all faculties. If there were any difficulties, they were minor ones, usually associated with the fact that we lived, for a number of years, in a state of physical chaos with jackhammers working overhead or underneath, construction workers knocking down walls out-

side your door, or walking through your office or laboratories to rip out old equipment and install new equipment. We lived so long this way that, after a while, we scarcely noticed it.

I was also fortunate in having as my predecessor, Dr. John Scott, who was a constant source of help and encouragement to me. I think it is quite remarkable that the four Chairmen of the Departments who succeeded one another after his retirement in 1954 were all former students of his. I am sure it must be a record of some sort. We are fortunate in having a photographic record of that group. Dr. Scott continued on after his retirement from the Department for a period of five years as Dean, and this was of great help to me, as I gradually began to feel my way along in the Department.

If I had my professional life to live over again, I don't think I would have done anything differently. This has always been a source of great satisfaction to me that I had the good fortune to live in such happy times and to work with such an active group, not only within the Department, but with the Chairmen of the other Clinical Departments as well. When I was trying to make up my mind as to whether to stay on as the Chairman of the Department or to move over to the R.S. McLaughlin Examination Research Centre, to get it on the road, Gordy Kerr, I think, really precipitated the decision for me when he said to me one morning when I was talking to him about it, "Don, what do you think you can prove by staying on for a sixteenth year as Chairman of the Department that you haven't already proved in the first fifteen years?". I must admit this stopped me in my tracks. During thinking it over that evening, I came to the conclusion that I could really add nothing further (other than more of the same), therefore, the decision to switch over to the fledgling Centre was an easy

one. From that point on, for a period of ten years, I continued as a member of the Department of Medicine, but devoted my major efforts to the development of the R.S. McLaughlin Centre.

Although budgetary figures aren't the be-all and end-all in judging progress or lack of it, quality or no quality, as I indicated at the onset, the department budget in 1954 was $10,000 ($4,000 of which went to the Dean's office) and this money had to cover everything in the Department of Medicine and its branches - Pediatrics, Psychiatry, Public Health & Preventive Medicine and Rehabilitation and Physical Medicine. In 1969, the Department of Medicine operational budget alone was $330,940 the research budget was $437,284 plus the transplant group budget of $1,250,000 spread over a five year period and $80,000 for the operation of the Edmonton Unit of the McLaughlin Centre. The research budget for the whole faculty was $2,045,000 as compared to $10,000 in 1954.

Dr. D.R. Wilson

HISTORY OF THE DEPARTMENT OF MEDICINE

DR. ROBERT S. FRASER

Professor and Chairman

Department of Medicine

1969 - 1974

ACKNOWLEGEMENTS

To Dr. George Molnar, Chairman of the Department of Medicine belongs the credit - or blame - for suggesting I undertake this project.

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R.S. Fraser

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DEPARTMENT OF MEDICINE

1969-1974

A PERSONAL VIEW

ROBERT S. FRASER

In February 1980, Dr. George Molnar, Chairman of the Department of Medicine, sent me a manuscript entitled "History of the Department of Medicine, 1954-1969", written by Dr. Donald Wilson, Chairman during those years. Dr. Molnar asked me to write a sequel which would describe the activities between 1969 - 1974 when I was Chairman. Both the history of Dr. Wilson and the memoirs of Dr. John Scott (1914-1979) provide not only factual information about the first fifty years of the Faculty of Medicine, but also constitute fascinating commentary and reminiscences of two important contributors to the first 50 years of the Department of Medicine.

The documents I consulted were all those records available in the Department of Medicine, including minutes of meetings, annual reports and the chronologic collection of my correspondence. The minutes of the Faculty of Medicine Council provided useful information concerning the changes occurring in the faculty and in the University as a whole. Minutes of the Special Services

and Research Committee of the University Hospital, reports to the Medical Staff Advisory Committee of the Hospital and copies of the "Twelfth Street Beat" helped to reconstruct those years in which the Hospital and Faculty strove to bring into being a Health Sciences Centre.

Two histories proved to be both interesting and helpful. Dr. John W. Scott, former Professor of Medicine and Dean, wrote "The History of the Faculty of Medicine of the University of Alberta, 1913-1963" to mark the 50th anniversary of the founding of the Medical School. The "First Fifty Years, The University of Alberta Hospital, 1914-1964" was written by Dr. Angus C. McGugan, Superintendent from 1942-1960 and later Hospital Archivist.

Memory is not only faulty but selective; emotions evoked by the intensity of debate and by presenting a case for one's department can often be recalled more vividly than the facts. What one would like to think had occurred may in the course of time become what did occur. The interval of sixteen years since I accepted the chairmanship has doubtless made difficult an accurate reconstruction of events. For this reason I have tried, by reference to all available primary sources, to present events as they occurred, to put them into the larger context of the Hospital, the University and the "seventies," and to attempt to describe our mixed emotions of disappointment, frustration, hope and optimism.

CHAPTER I

EVENTS LEADING TO 1969

THE BRIDGING FACULTY

The Faculty of Medicine of the University of Alberta is young. Our first graduates, a class of 11 men and women were granted their degrees in 1925. Youth is, nevertheless, relative. Since the end of World War II, full medical faculties have been established at the Universities of British Columbia (1950), Saskatchewan (1953), Sherbrooke (1961), Ottawa (1945), Calgary (1967), McMaster University (1967) and Memorial University (1967). Seven of the existing sixteen Faculties of Medicine in Canada are indeed our juniors.

Those of us who graduated at the end of the War, and who are now about to retire, constitute a bridge between the founders -- the pioneers -- of our Faculty and those clinician-scientists who will lead the department through the next half-century.

On one side of the bridge are the physician-teachers, part-time and largely unpaid, dedicated to the belief that here in a city of less than 100,000 persons they had an obligation to instruct others in their profession - "to teach them this art if they so desire". True to the Hippocratic oath most of them did so "without fee or written promise".

We on the bridge had as our Dean, Dr. Allan Rankin, the first dean of the faculty; as Professor and Head of the Department of Medicine, Professor Egerton Pope, the first "geographic" full-time clinical teacher in Medicine (Dr. John Scott, who succeeded him in 1944, was part-time); as Professor of Bacteriology and Hygiene, Dr. Robert Shaw; as Professor and Head of Pathology, Dr. J.J. Ower; and as Professor and Head of Physiology, Dr. Ardrey Downs. Dr. Ralph Shaner, First Professor of Anatomy, continued teaching until he established a record of having taught every medical class at this University for the

first 50 years of the faculty's existence, and continued teaching part-time for another four years until the year before his death in November, 1976.

Dr. Shaner summarized his pedagocic philosophy in a letter to me of June 12, 1971; "A teacher of basic science in a medical school is always in a peculiar dilemma. To be a good teacher he must love his subject for its own sake; yet he must constantly remind himself that his students must value other things as they take on the duties and responsibilities of a practitioner. I tried to keep the students' point of view always in mind." With unusual success!

As a student, one takes such men for granted, casually assuming that most teachers possess those same qualities of loyalty to the institution, dedication to the profession and an inate ability to inspire their young confreres. I will always consider it to have been my great good fortune to have been taught and I hope, molded in my career by a truly remarkable group of physicians.

What changes took place as the bridge was crossed? Many developments took place during the last several years of Dr. Scott's chairmanship (or Headship as it then was) and while Dr. Wilson led the department through the exciting expansionist times between 1954 and 1969.

The Faculty was introduced, although without initial enthusiasm, to the concept of geographic full-time clinical appointments. Graduate training programs expanded and became more formalized under the direction of Dr. Mark Marshall (Levey) and later Drs. Grisdale, Kling and Rossall. Research developed in the clinical departments with the support of voluntary health organizations as well as funding from the Medical Research Council which identified clinical research as an area of need.

Whereas the thirties, forties and fifties produced the specialists, the sixties and seventies saw the development and formal recognition of the sub-specialities by the Royal College and the provincial licensing authorities.

At the end of the Second War, the University consisted of seven faculties; by 1969 there were twelve faculties and five schools. Seventeen professors constituted the Council of the Faculty of Medicine in 1946; this had expanded to 101 listed in attendance in 1969. The University Hospital boasted 700 beds at the end of the War but with the addition of the 1953 and 1957 (Polio) wings and the provision for radiology, clinical laboratories, emergency and outpatient facilities in the Clinical Services Wing, the annual report of 1960 listed 1254 beds.

During the fifteen years in which Dr. Wilson headed the department, the number of practising physicians in the province increased from 963 to 1968; over the same period the registered specialists disproportionately increased from 290 to 796 (from 30% to 40% of practising physicians). At the time of writing in 1985 the number of practising physicians has exceeded 3600 and of these 46% are specialists.

Dr. Wilson has referred to the many other changes in which he played a major role during that exciting era of expansion. In those heady days the challenge was to think up proposals - the money seemed to be there for any reasonable project.

The department owes much to two benefactors whose support played a major role in sowing the first seeds which led to the growth of a geographic full-time faculty. Dr. Wilson was the first Albertan recipient of a Markle Scholarship in Medical Science in 1949 - an award of $6000 per year for 5 years. This program of the Markle Foundation was established in 1949 to encourage

young medical graduates to remain in academic positions of teaching and research. Although the Foundation was American, with headquarters in New York, the Board had come to the generous conclusion that Canadian faculties of Medicine should share in the benefits of the endowment. Before the termination of the scholars program in 1969 some 506 young people in 90 medical schools had been subsidized in the first five years of their careers. Many had gone on to responsible senior positions in Academic Medicine in both the United States and Canada.*

In 1952, I returned for a visit to Edmonton from Minneapolis where I was a Fellow in Medicine in the graduate training program. While walking down 89th Avenue past the old Med. Building, I stopped to chat with Dr. John Scott who had largely been responsible for two aspects of my program of graduate training. The first led to my enrollment as a Master's student in the Department of Biochemistry during one year of my graduate training program, supported by a scholarship of the then Medical Division of the National Research Council of Canada. Dr. Scott had spent several years of his early career in biochemistry and had both a continuing love for it and a phenomenal memory for everything he had ever learned. His advice had been appropriate and timely in that he viewed biochemistry as a more useful basic science for those in internal medicine than gross pathology. Unfortunately, the Royal College did not

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*More graduates of the University of Alberta received Markle Scholarships than any other medical school in Canada and only three American Schools of Medicine exceeded or equalled six scholars (Fraser, McCoy, MacLean, McLeod, Pierce, Wilson).

demonstrate comparable foresight and, when I tried the Fellowship in 1953, still demanded a separate paper and an oral/practical exam in pathology. Only through the generous assistance of Barry Pierce, now Professor and Chairman of Pathology at Denver did I ever overcome my obvious deficiences in Pathology, and then only long enough to satisfy Drs. Lyman Duff and John Hamilton.

The second influence Dr. Scott exerted was to suggest I go to Minnesota to train in the department of Dr. Cecil J. Watson, a friend of his and a widely known and respected teacher and medical leader in the United States. This arrangement had a much more satisfactory ending than the first.

To continue - Dr. Scott learned that I was about to spend my next and last year in Minneapolis as a research fellow working for Dr. Carleton Chapman (later Professor of Cardiology at Southwestern University, Dallas and then Dean of Medicine at Dartmouth). Dr. Scott told me that Dr. Joseph Dvorkin had returned to practise at the University Hospital and the Royal Alexandra Hospital after taking graduate training under Dr. Arthur Master, Dr. I Snapper and Dr. Friedberg in New York. He and Dr. Gordon Bell had spoken to Dr. Scott about having me come back to establish a cardiac catheterization laboratory. Dr. Scott went on to say that the faculty would propose me for a Markle Scholarship which by great good fortune I was awarded in 1953, to begin upon my return to Edmonton.

There were two other Canadian recipients and 18 from American medical schools that year. The opportunity to meet annually with these fellow scholars and those from earlier and later years was stimulating and unforgettable.

By 1953, the Department of Medicine could boast diagnostic laboratories in Endocrinology/Metabolism (Dr. Wilson) and Cardiology (Dr. Dvorkin and I), attributable in no small way to a generous American Foundation. A short time

later Dr. Lionel McLeod became the third recipient of a Markle Scholarship, returning to pioneer the development of a renal service in addition to contributing in his area of expertise in Endocrinology.

The second benefactor, already recognized by Dr. Wilson in his record, was largely led to her interest in supporting the development of the department through the long-standing persuasive efforts of Dr. Wilson, who also acted as her family physician and advisor. Mrs. Gladys Muttart, the public-spirited wife of Merrill Muttart, a lumber merchant and business man, contributed in many ways to medical education. I personally was the beneficiary of support through the Muttart Associated Professorship in Research which lasted from 1955 to 1961. I was hesitant about accepting this and in retrospect believe I was not able to fulfill the expectation of those who designed it. My interests were in the development of the Division of Cardiology and in the clinical research which could spring from this. I am sure that another recipient who saw research as the primary objective would have been a more appropriate choice. Be that as it may, their support ensured the continuation of the geographic full-time concept and the Muttarts, with the excellent advice of Don Wilson continued to support the department even to the present time, when the foundation which has survived them supported the establishment by Dr. George Molnar of the Muttart Diabetes Research and Training Centre.

Dr. Scott referred to his "chagrin" in 1948 when he found, on assuming duties as Dean, that heads of basic science departments were paid a maximum salary of $4500 with no provision for increment. The Markle award of $6000 in 1953 must have seemed to him, as it did to me, to be most generous. There was little formality to appointments in those days - no contract, no job description, just a chat and a handshake followed by a congratulatory welcome note

from the President. Dr. Scott, mindful of worse times, exhibited his inherent caution, saying to me that he thought I should draw $4800 but leave $1200 of my annual award to take care of other things. This I did, stretching the funds well beyond the five years and allowing us to provide travel funds for Joe Dvorkin and an initial salary for Dick Rossall when he joined Cardiology as its second geographic full-time person in 1957.

Both Dr. Wilson and I, as the first geographic full-time clinical appointees, took part in the initial agreements concerning professional earnings. These arrangements were suggested by Dr. Scott to the President and through him to the Board of Governors of the University of Alberta and permitted us to earn in professional activities an amount equivalent to our salaries, with a hard ceiling. Dr. Stewart, then President, expressed misgivings about this arrangement to Dr. Scott because he recognized that faculty members in other disciplines such as engineering were also earning outside professional income and he felt uneasy about singling out one faculty for regulation. The arrangements for Dr. Wilson and me remained unchanged until Drs. Macbeth and Harrison joined the Department of Surgery, when the Dean was persuaded by Dr. MacKenzie, Professor and Head of Surgery to alter the agreement such that a common limit of $10,000 was applied to the four of us and the ceiling became soft, with a return of 50% of any excess to the University.* Dr. Wilson and

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*This revised arrangement was described in a letter of April 10, 1959, to the Heads of the Department of Medicine (Wilson), Pediatrics (Martin), Psychiatry (Yonge) and Surgery (Mackenzie) from Walter Johns, President, following approval by the Board of Governors on April 3, 1959. The agreement included the proposal to review the conditions of employment in three years.

I, to the best of my memory, were not advised of the proposed change until after it had been accomplished (evidence, I thought, that Surgery was being accommodated at the expense of Medicine since we were satisfied with our existing arrangements).

THE BUILDING PROGRAM

The sixties was a decade of growth and planning. The Executive of Faculty Council agreed to the appointment of a consultant to examine and advise on the space requirements of the Faculty in November 1962.

Dean MacKenzie had prepared a brief to the Campus Planning Committee and to the Board of Governors entitled "Brief Referable to Space Requirements in the Faculty of Medicine" in August of 1962. The need for a "Teaching Building" was referred to in minutes of the Executive of the Faculty the year before. The Faculty was offered the former building of the Faculty of Education (Corbett Hall) and it was for this rather old building that plans were to be made. The impetus for requests for space appears to have grown out of the perceived "urgent" need for an auditorium for clinical teaching — a request which had been approved in principle but for which funds had been withdrawn from the Hospital budget in 1961.

In the brief Dr. Mackenzie listed as a requirement in the immediate future a Clinical Teaching Wing. Added to this were a building for the schools of Nursing and Rehabilitation and a building for Bacteriology and Pathology. The faculty of these schools and departments were to be removed from the Medical Sciences Building to permit expansion of all the basic science departments of the Faculty.

The deliberations of the Royal Commission on Health Services had made it probable that government sponsored health insurance would be introduced and would increase the need for medical graduates thereby leading to an expansion of the undergraduate program.

In the Dean's letter of May 22, 1964 to President Johns, he recapitulated the growth of the clinical faculty which he described then as "squatters" in the University of Alberta Hospital which had been generous in providing us with space over the preceding decade. Estimates of the cost of renovating the old Education Building had been too high and the plan was discarded within a year of the time it was first considered.

Between 1964 and 1967 much planning was done. The concept of a Health Sciences Centre was attractive to both those in the administration of the Hospital and the academic leaders in the schools and faculties of the Health Sciences.

In November 1965, following meetings involving the University Administration, the Faculty of Medicine, the Hospital Board and Hospital Administration and the Departments of Public Health and Public Works, permission was received to plan the development of a Health Sciences Centre to the south of the University Hospital.

Dr John Read, who was appointed Planning Co-ordinator for the Health Sciences Centre, joined Dean Mackenzie in producing a document entitled "Planning for a Health Sciences Centre to Provide Comprehensive Medicine Care" (April 1966). In this paper they advocated comprehensive medical care and stressed the need for preventive and rehabilitative medicine and the use of expanded facilities for the ambulant patients. They saw professional care being provided by Nursing, Pharmacy, Dentistry and Rehabilitation Medicine as

well as by our own faculty. The popular term was "a team approach". It should be noted that they wrote that "the University Hospital must also maintain its status as a community hospital".

The approval referred to above had consisted of permission to plan a Clinical Sciences Building (formerly approved as the Clinical Teaching and Research Building) and extensions to the Provincial Laboratory to accommodate academic and service functions of Bacteriology and Pathology. The Hospital received approval for a building to contain an auditorium, health sciences library, a cafeteria and a food services centre.

Of more direct interest to us was the permission given the Hospital to develop plans for a Clinical Specialty Unit to contain facilities for Cardiac Medicine and Surgery, Neurology and Neurosurgery, Nephrology, Organ Transplantation Unit, Intensive Care Unit and a Ambulatory Care facility. It was out of this that the Centennial Hospital almost became a reality. Growing out of these proposals came the appointment of "T.R.W." of Los Angeles. This firm had been involved in the space program but saw an opportunity to diversify into the rapidly expanding health care "industry". They were commissioned to develop a plan for a Health Sciences Centre and from 1966 to 1968 many of us spent countless hours introducing members of the T.R.W. team to the requirements of our various divisions.

On June 30, 1966, representatives of the University of Alberta Hospital and "others interested in the development of the Health Sciences Centre" met with the Hon. J. Donovan Ross, Minister of Health and the Hon. Fred C. Colborne, Minister of Public Works concerning the "Interim Report on Hospital Components of the Health Sciences Centre". This document contained data justifying needs for those units listed above.

The total bed requirement was 615, with 70 of these classified as intensive care. This would have increased the total beds from 1254 to 1478 in the University Hospital complex. The plans included demolition of the Mewburn Pavilion (239) but with recovery of another 162 beds in the existing hospital. The plan was to build a specialty hospital (The Centennial) and relegate the existing hospital to providing community service.

Dean Mackenzie and Dr. Snell visited Health Science Centres in Missouri, Kentucky and Florida in 1966 and provided a report in September that year entitled "Report of a Survey Trip to Three Health Sciences Centres in the United States in preparation for Program Formulation and Physical Planning of the Health Sciences Centre in the University of Alberta, Edmonton". It was interesting to see reference to Dr. Ernest McCoy, later to become Chairman of Pediatrics at the University of Alberta, who was on the Faculty of the University of Missouri in 1966. It was on this visit that they noted that the University of Missouri had 210 full-time and 150 part-time staff for an intake of 85 students. It is difficult to know from reading the report how much the survey influenced the plans for Alberta but the information they gained may well have been useful in the eventual development.

Ronald Clarke had been appointed project director of the proposed Centennial Hospital of the University of Alberta Health Sciences Centre. The consultants from T.R.W. continued their determined attempts to introduce technology into an industry which they obviously considered was struggling along with outmoded pencil, paper and telephone. The experience of mutual education was not always exhilarating or enjoyable but both they and we eventually began to understand a little about each other.

The Centennial Hospital was designed so that each of its eight floors supported a clinical specialty and the ground floor provided an ample area for ambulatory care. The latter was a favorite project of planners and hospital administrators who were persuaded that effective use of out-patient facilities and day care would reduce the need for beds and interrupt the escalation of hospital costs.

MEDICAL SCIENCES BUILDING

Tenders were called on November 3, 1969 for a building to house the basic science departments. This was to be erected immediately west of the Mewburn Pavilion. As further hospital development took place it was hoped that the basic scientists and clinical members of the faculty would overcome difficulties of communication and cooperation which had been aggravated by the physical separation of the Medical Building and the Hospital.

THE WESTERN CANADA HEART INSTITUTE

Dr. John Callaghan, director of the Division of Cardiothoracic Surgery, with his characteristic enthusiasm and salesmanship, persuaded the Health Minister Dr. J. Donovan Ross that the planned addition to the University Hospital should include an area dedicated to cardiac surgery (and cardiology). In a press release in January, 1966, the Minister announced "approval in principle" of construction of a $10 million Western Canada Cardiology Institute which would occupy one tower of a proposed twin-tower building at the site of the University Hospital.

This proposal embodied John Callaghan's vision of a centre serving the four western provinces and he did not consider it presumptuous to refer to

it as the Western Canada Heart Institute. Others had reservations about such an "institute" and it did not receive the necessary support from the Medical Advisory Board or the Division of Cardiology. Some expressed their opinion, rightly or wrongly, that institutes tend to become isolated from the mainstream of medical care and that patients suffer from fragmented subspecialized attention. Several of the "non-surgical" proposed tenants feared that they would be dominated and directed by a completely surgical administration with goals inimicable to them as internists.

Although the lack of support from the essential groups - the senior department heads, the administration and the division of cardiology - undoubtedly interfered with further development of Callaghan's proposal, subsequent retrenchment of the Government in 1968-69 leads me to believe that the Western Canada Heart Institute was not a viable plan at that time.

NORTH GARNEAU DEVELOPMENT

While planning was taking place in the Hospital, the University was moving rapidly to ensure orderly expansion to accommodate a predicted enrollment by 1972-73 of 21,500 full-time students. By 1968 Bittorf and Pinckston had developed a comprehensive plan referred to as the North Garneau Development. It was obvious then, as it is now in 1985, that there must be co-operative integration of the plans of those two large institutions, the University and the Hospital. This was particularly so in the matter of transportation and it is interesting in retrospect to read of the proposed development of a rapid transit system to the University Hospital which was planned for completion by 1970-71. In 1985 the City Council was still arguing!

Although changes were made in the initial plans for North Garneau development, the essential elements were maintained. Property was acquired for an impressive program resulting in new buildings on the campus for the Library, Agriculture, Business Administration and Commerce, Fine Arts, Humanities, Social Sciences and Law.

THE START OF THE RECESSION

Planning by the Hospital gained momentum during 1966 and by 1968 the enthusiasm of the participants had exceeded the "generosity" of the donors. The Long Range Planning Committee of the University Hospital had collated the projected requirements from each of a number of planning sub-committees. In some instances these sub-committees represented interests of related areas such as cardiology,* pulmonary disease and cardiothoracic surgery. We submitted a report from these three related disciplines to the L.R.P.C. on March 9, 1966, describing and justifying our predicted needs for space, facilities and equipment for both patient care and clinical investigation.

We were soon to be reined in. A memo to departmental and divisional heads from Dr. Snell, Executive Director of the Hospital, dated September 3, 1968, described a situation with which we all became increasingly familiar over the next 25 years. "The projected cost of the Centennial Hospital . . . . . was found to be considerably more than the Government had anticipated".

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*Long range plans for the Division of Cardiology and Pulmonary Disease had been developed earlier for the Head of the Department of Medicine (1963).

The concept of a Health Sciences Centre began to suffer from the financial restraints which led the Provincial Executive Committee to "postpone consideration of the Centennial Hospital for a period of at least one year."

The Hospital Board managed to persuade Government that such a delay would have serious effects on essential expansion of medical services, and a compromise agreement was reached under which the proposed program would be reduced to a minimum necessary to "maintain the concept of the Centennial Hospital and the Health Sciences Centre". The building would be done in three phases: the first to be finished in four years and the third by nine years.

Three stipulations were succinctly stated in a letter from Premier Manning to the Hospital Board in late 1968:

(1) That the cost should not exceed $27,025,960 (1968 dollars), plus approved equipment and professional fees.

(2) That funding would extend over an 8 year period.

(3) That no changes which would increase costs could be made.

Premier Harry Strom replaced Mr. Manning who had retired as leader of the Social Credit party and after 26 years as premier. In a letter to Mr. Gordon Wynn, Chairman of the Board of the Hospital, Mr. Strom acknowledged the Board's acceptance of the conditions set out by Mr. Manning and stated that funds for the first year would be in the budget for April 1, 1969. This, we thought, marked the start of a clearly defined building program which would furnish us with the necessities, albeit not everything we thought we needed or deserved. Little did we know that it would be sixteen years before we would move into new hospital facilities. More about the Health Sciences Centre later.

Mr. Manning's letter had contained the additional prophetic and gloomy forecast that "... because of the serious financial situation with which the Province is faced in the forseeable future, it is imperative that there be a definite understanding...".

If we got the message few of us recognized the import of what Mr. Manning was saying.

CHANGES -- MEDICAL CARE AND MEDICAL EDUCATION

In 1967 the medical world was startled, and then divided in opinion by the report by Dr. Christian Barnard in South Africa that he had performed the first successful human heart transplantation.

Late in 1968 a meeting was held in the University Hospital to discuss "the state of preparedness" for heart transplantation. Dr. S. Lee and Dr. R.F. Taylor visited Montreal and Toronto where programs of cardiac transplantation had been started. It was concluded, at least in the Division of Cardiology, that long-term results were unknown; that rejection remained an unsolved problem; and that the demands of long-term care in Cardiology, Immunology and the Laboratory might prove impossible to meet with our staff at that time. In a letter to Dr. Snell (December 20, 1968) I pointed out that we were having difficulty providing adequate follow-up care to the increasing number of patients with artificial heart valves, and would have great difficulty taking on an additional program.

Now in 1985, seventeen years later the Hospital Board agreed to three cardiac transplants as a start to a program which, it is hoped, will receive government support in the future.

No medical school can resist for long the urge to revise the curriculum, fed as we are by discontent from within resulting from the minimal effect of annual cosmetic changes in the curriculum, and exposed to the temptation to follow the lead of other schools in seeking instructional Nirvana. Because the adoption of the new curriculum took place during my term as chairman (and the consequences contributed to several problems to be described later), I believe a brief description of the process of revision should be offered here.

In a memo describing the new curriculum in 1969 we read that:
"The Dean of Medicine and several responsible members of the Medical Faculty have felt for some time that the traditional medical school curriculum, as utilized through North America, is not the best method of producing doctors to meet the needs of current society. Accordingly, in 1962 a committee on "Research in Medical Education" was established within the Medical Faculty of the University of Alberta.* This committee, under the chairmanship of Dr. J.A.L. Gilbert, met regularly for four years discussing good and bad features of medical education and good and bad features of the existing curriculum in this school."

This deliberation resulted in Medical Faculty Council accepting a recommendation from the Committee in 1966 that it be replaced by a Curriculum Advisory Committee whose purpose would be to design a new curriculum for the Medical School. This new committee, again under the chairmanship of Dr. Gilbert reported to Faculty Council on May 10, 1968.

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*A "curriculum study group" consisting of the Curriculum Committee, department heads, the Dean and Assistant Dean and Dr. George Miller of Chicago met in Banff, October 20-22, 1961.

The proposed new curriculum was designed to correct deficiences which were identified as:

(1) Inflexibility of the program which did not take into consideration the diverse educational and personal backgrounds of entering students.

(2) Time rather than purpose orientation in the presentation of subject matter.

(3) Departmental orientation with a lack of interdisciplinary coordination.

(4) Lack of relevance of material as perceived by the students.

(5) Impairment of motivation to become physicians by late introduction to patients.

Fourteen years later I was responsible as Acting Dean for appointing another committee to again review the curriculum after the faculty generally agreed with a recommendation by the Committee on Accreditation of Canadian Medical Schools that we should examine both the inadequacies of content of our current program and the difficulties which seemed to have arisen from the changes made in 1969.

CHAPTER II

THE WORLD AROUND 1969

Nineteen sixty-nine was a turbulent year. As the publisher of the Britannica Year Book wrote, "Along with the revolt of youth, racial conflict plagued the United States." University Hall at Harvard was seized by 300 militant students; Howard University closed after 8 buildings were taken over by students; Cornell was faced with armed Black students; the President of City College, New York resigned when forced to re-open the institution after a take-over by Black and Puerto Rican radicals. The Black Panther Party was charged with plotting to bomb stores in New York.

On January 20, 1969, Richard Nixon took the oath of Presidential office, while in Canada the Secretary of State for External Affairs, Mitchell Sharp, denounced the signing of letters of agreement between Quebec and France concerning scientific and economic matters. A Federal-Provincial conference on revision of the constitution again adjourned without progress.

Golda Meir became Prime Minister of Israel and was appreciably more interesting than was Harold Wilson, Prime Minister of Britain. The Concorde made a successful first test flight and threatened to change the pattern of Trans-Atlantic travel.

On June 3rd, Edgar Benson, Minister of Finance in Trudeau's government, introduced an "austerity budget" and a few days later the Bank of Canada rate reached a record level of 8% by August.

Armstrong and Aldrin landed in the Apollo II lunar module on the moon, July 20, 1969. This event eclipsed most others of the summer dog days and little attention was paid to Trudeau's announced freeze on federal spending or Nixon's appeal for restraint to curb inflation.

At a special convocation presided over by Chancellor F.P. Galbraith, Dr. Max Wyman, formerly Chairman of Mathematics and then Vice-President (Academic), was installed as President of the University of Alberta on October 6, 1969. In his thoughtful philosophical address he examined the search for truth which he said "becomes the knowledge of each generation which in turn destroys the truth of all its predecessors". He spoke of dissent, but argued that freedom without consent is freedom not worth having, and cautioned that "in our zeal to protect dissent, it should not be overlooked that there must always be room for the majority."

He concluded by addressing the young people saying, "There is no hope that my generation will understand you, because you seek to destroy us, and you will successfully complete that destruction." He went on to describe his generation as the most fruitful generation in the history of man but acknowledged the problems left unsolved or newly created, especially in the social sciences. Despite this admission "the miracle is that we accomplished so much, not that we failed so often."

I had served on the Academic Development Committee under the chairmanship of Max Wyman when he was Vice-President (Academic) in a time when, as Grant Davy wrote, "he (Wyman) undertook most of the responsibilities later assigned to the Vice-President for Finance and Administration and the Vice-President for Campus Planning and Development".

His sincerity, his concern that decisions be fair and equitable, his determination that all interests be represented in the consideration of matters large and small and his willingness to discuss problems until a mutually agreeable solution was reached were characteristics he demonstrated to us on the committee and which he carried forward into his presidency. In retrospect, he was undoubtedly the right person to guide the University through the early seventies when student activism moved in from the United States where it had begun some three years earlier. His readiness to listen to the sometimes strident demands of students for representation and his awareness of the need to revise the constitution of many of the University Committees no doubt helped to restrain the student unrest on this campus. Our students "reached for political identity"* without resorting to threats and violence which characterized the student activity on a number of American campuses.

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*"Activists in Medical School" ed. New Eng. J. Med. 279:101 July 11, 1968.

ACADEMIC YEAR 1969-70

Early in 1969 some members of the department suggested that I submit my name to the selection committee which was to choose a successor to Dr. Don Wilson who was resigning on June 30 after leading the department through fifteen years of unprecedented growth and development. I had been director of the Division of Cardiology since 1954 when Dr. Scott confirmed the adoption of this functional title within the department of medicine at the University Hospital. There was a continuing challenge in cardiology but the department presented wider horizons and somewhat different problems which I thought I would like to tackle.

SELECTING THE NEXT CHAIRMAN

The selection committee met with me in the Faculty Club in the main dining room, in a small section isolated from the remainder by a folding partition. It was not the ideal site for a discussion about the future of the department, nor have I ever enjoyed combining a meal with business. The notes which I made for my presentation to the committee emphasized my belief that the chairman should be a facilitator — a person who would encourage each divisional director to develop an area of excellence. I thought that the department should be recognized as a University entity and not as part of the University Hospital. I stressed the importance of unifying the part-time and full-time members of the department throughout the city and attempting to reduce the unhealthy aspects of interhospital rivalry. There were several ways in which this might be brought about but one which I suggested, namely separating the chairmanship of the faculty department from that of the University Hospi-

tal department brought an early and unequivocal expression of disapproval from Dr. Bernard Snell who has always looked on the University Hospital as the "principal" teaching hospital while categorizing the others as affiliated institutions. He believed that all University chairmen should be sited at the University Hospital, be jointly appointed, and have a similar position within the hospital.

I told the committee that I considered the undergraduate teaching program to be the central focus of the department's activity. The other programs which were essential to the maintenance of successful undergraduate instruction were first class research to stimulate both students and staff, graduate training to contribute the first line of teachers at the bedside, and exemplary clinical practice to demonstrate the science and art of medicine and to attract patients by maintaining a reputation as a respected referral centre. I concluded by saying I believed that most chairmen should have a fixed term of office, and that I would be prepared to accept five years at the conclusion of which I would hope to have introduced, if not implemented, most of my ideas. In retrospect, I have come to believe that perhaps seven years is a more reasonable term. Although there are exceptions to this observation I believe that most academic administrators experience a waning of their initial drive and enthusiasm as their source of innovative ideas begins to dry up. It becomes tempting, perhaps essential, to "consolidate" one's administrative position, building some protection against the desires for change which normally start to surface as the momentum of the administration falters. My resolve remained firm and at the end of my five year term I was satisfied to step down.

There were undoubtedly members of the department who would have preferred to have had an "outside" appointment but after taking over the duties on July 1, 1969 I was gratified by the subsequent evidence of their loyalty to the department and by the support I was given in trying to weather the effects of the new curriculum, few added staff, and with the problems of a restrained budget — more of this later. I will always appreciate my predecessor's determination to leave me to my task as chairman; indeed it was difficult to persuade Don Wilson to give me advice even when I sought it. No one could have asked for more thoughtful treatment.

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The narrative which follows concerns the Department of Medicine over the following five years. The emphasis placed on events is my own; wherever possible, correspondence, minutes of meetings and other documents were used to construct this record. Unfortunately gaps appeared in the reference material and some files have disappeared. For inadvertent inaccuracies, I apologize.

THE TRANSITION PERIOD

DIVISIONALIZATION

The advent of the subspecialities in Alberta had not been through formalized training programs - approved by the Royal College and followed by recognition of the trainees as subspecialists after appropriate examinations. All of this gradually evolved, but during the 1950's and 60's some general internists, (and pediatricians and surgeons) pursued special interests within their general specialty. The inducement to practice within a subspecialty became

stronger as information specific to subspecialties began to accumulate with increasing rapidity. A second and a sometimes important influence in the segregation of subspecialties within the established general specialties was the development of special techniques such as endoscopy in gastroenterology and catheterization in cardiology.

The pioneer subspecialists were those people who after developing their skills and experience through practice were considered by their peers to be able to offer something more in their special field of interest than the general physician or pediatrician or surgeon. During the transitional stage a number of the general internists clung to the hope that everyone could continue to practice effectively as a general internist while he also developed the special knowledge and skills of a subspecialist. I remember Dr. John Scott cautioning me in 1953 that it might not be wise to establish weekly cardiology rounds since this might tend to detract from grand medical rounds and fragment medicine within the University Hospital; this despite Dr. Scott's established and continuing support of each of us who had developed an area of special interest.

Dr. Don Wilson had appointed a number of divisional directors or chiefs in the University Hospital during the fifties and sixties. (The University did not and still does not recognize any administrative organizations below that of department). In 1969 there were directors in endocrinology and metabolism, nephrology, respiratory diseases, cardiology, dermatology, rheumatology, immunology, hematology and infectious diseases.

Despite the recognition of directors, no separation of the staff in medicine into these divisions had been attempted, although informal groupings had existed for 15 years. This was in contrast to surgery in which the staff had

for long been identified in divisions of neurosurgery, orthopedics, plastic surgery etc.

I thought it would be helpful to me, as chairman, to be able to rely on direct and frequent contact with the divisional chief through whom concerns and suggestions could be brought to the office of the chairman and who in turn could be responsible for implementing, within the division, departmental policies and other regulatory matters originating in the Hospital and the Faculty of Medicine. I also thought that we were at a disadvantage when forced to make our case as a single organization while surgery seemed to be able to make separate claims for each of their several divisions.

I saw two potential problems: first that we had a number of people on staff who had more than one special skill or interest and who might find it unacceptably restrictive to declare themselves for membership in any one division; the second was a well-founded concern that some divisions might grow too powerful and in doing so, through perfectly commendable expansion of their clinical, research and consultative activity, become insensitive to the needs of the department as a whole. Perhaps the second concern was a predictable and inevitable concomitant of divisionalization.

On September 29, 1969, a provisional listing of all existing staff in medicine at the University Hospital was provided to each divisional director, suggesting each person's divisional affiliation. This was based on the type of practice of the staff person in the past; it also recognized the expressed wishes of the staff person and his divisional chief. At the next regular meeting of divisional directors on October 8, 1969 the membership of divisions was formalized. The directors at that time were:

1. Cardiology - Dick Rossall

2. Hematology - Adam Little
3. Endocrinology - Mo Watanabe
4. Respiratory Diseases - Brian Sproule
5. Nephrology - John Dossetor
6. Neurology - George Monckton
7. Gastroenterology - Ron Wensel
8. Rheumatology - John Percy
9. Infectious Diseases - George Goldsand
10. Dermatology - Paul Rentiers

Let me point out again that divisions and divisional directors had been introduced into departmental structure by Don Wilson during his chairmanship - I thought the time had come to continue divisionalization to the point where each person belonged to a "home" division.

The Directors of Divisions continued through the next five years to act as a sort of cabinet, meeting every few weeks. Although their jurisdiction was theoretically confined to the University Hospital they did, in fact, act for their subspecialties in all matters of concern to the University department. During my chairmanship there was scanty representation of the subspecialities throughout the other city hospitals, certainly to the extent that specialists confined themselves to the practice of a subspecialty, the exceptions being Neurology and Dermatology. Both because of this and because there seemed at that time to be no potential divisional directors on the staff of the other affiliated hospitals, I did not agree with the suggestion (which became more insistent as time went by) that we should institute a city-wide divisionalization of the department. Moreover, I suspected that our faculty in the other hospitals would see such an arrangement as the imposition of "Uni-

versity Hospital" control over matters that they considered should remain under their own jurisdiction. In addition, I could see no advantage accruing to our teaching or research programs at that time through such an arrangement. I thought that there should first be evidence that subspecialists sought such affiliations themselves -- as was the case in the Department of Surgery where weekly rounds were attended by all the urologists in the city, and in our own department where the neurologists held joint rounds at the Royal Alexandra and the University Hospitals. Nevertheless, the increasing desire to recognize divisions as faculty units resulted in the appropriate action while Brian Sproule was Acting Chairman between the end of my term and the beginning of George Molnar's (July 1, 1975). The staff has been listed in the calendar in divisionalized fashion since that time.

COMMITTEES AND MEETINGS

LONG RANGE PLANNING ADVISORY COMMITTEE

There were ten divisional directors in August 1969, a number too large to gather as often as I thought necessary to advise me on policy and long-range planning. I also wished to signal to members of the department throughout the city that we were indeed a city-wide department by including representatives from the other hospitals in as many of our committees as appropriate. In appointing an advisory committee, referred to also as the long-range planning committee, I sought persons who could represent the geographic full-time staff, the part-time staff at the University Hospital, the part-time staff at one of the other affiliated hospitals, and the research interests in the department. These people were to study problems related to our activities in

the University and to advise me with respect to the course we should follow. The committee was to concern itself primarily with matters of policy. They could also determine what items deserved their study.

The first members of the Advisory Committee were Adam Little (Chairman, Geographic Full-time Clinical), Dick Sherbaniuk (Part-time University Hospital), Mo Watanabe (Research Interests) and Rod Eidem (General Hospital). Gordon Kerr, the department's Administrative Officer acted as permanent secretary. The first meeting was held on September 16, 1969 and I discussed with them what I had in mind. In particular, I hoped that they could develop a rational system for the expansion of the department such that new appointments should be made in conformation to the long-term plans of both the division and the department as a whole. I hoped to reduce or avoid the tendency to name a prospective staff member and then, after this, to design the position and draw up the terms of reference. The more desirable alternative which I hoped we could follow was to ask each division to submit its long-range plans and the manpower requirements. The Advisory Committee was expected to act as an impartial body which would establish priority among the vacancies which were identified in the divisional long-range plans. I did not believe this could be done by the divisional directors, each of whom by the nature of his appointment had to act as advocate for his own division and could not be expected to set self-interest aside to look at the interest of the department as a whole.

This concept was not acceptable to some directors and eventually sufficient resentment of this sytem arose so that the Advisory Committee was finally dissolved, a matter which will be discussed later.

The Long Range (Advisory) Committee met first on September 16, 1969 and continued to meet every two weeks during the academic year 1969-70. In the fall they collected data concerning the teaching loads of all our staff -- in all teaching hospitals. Ron Eidem and Adam Little visited the Misericordia and General Hospitals, and Mo Watanabe and Dick Sherbaniuk the Royal Alexandra Hospital. Similar data were then obtained from departmental members at the University Hospital. The committee found the occasional wide discrepancy between the estimate of teaching time by the staffmen and the students or residents, but this varied in both directions. Of 80 persons listed in the department, approximately 20 made little or no contribution to teaching because they were retired, semi-retired or in a subspecialty which was not called on for ward teaching.

The committee reviewed long-range plans which were submitted by each divisional director. These proved to be essential when departmental goals and priorities were discussed. It was readily apparent that each division was in need of added staff. In some divisions there were no members supported by University "hard" funds and in the majority there was not a viable group. The committee advised me concerning the priority which should be allotted to the positions which the divisional directors wished to have established. In this respect they agreed, at my urging, to give first priority to a new position for director of the division of General Internal Medicine. I saw a strong division providing the ward experience for the student interns in Phase III of the new curriculum. I also thought it would be desirable to permit the subspecialists to practice in their areas of declared interest and expertise without having to accept responsibility for undesignated patients of all sorts admitted through the Emergency. It was difficult too, in many cases, to avoid

giving continuing care as had been the custom in the practices of Drs. John Scott, Frank Elliott, Joe Dvorkin, Ted Donald, Ken Thomson and others.

The list of positions to be filled in order of priority, after Internal Medicine were: Gastroenterology, Hematology, Royal Alexandra Hospital Teaching Unit, Infectious Diseases, Endocrinology, Pulmonary, Cardiology and Nephrology. This was admittedly an arbitrary listing but it established a working plan and it was agreed that priorities could be changed if conditions altered or particularly talented people became available.

The committee recognized that in the University Hospital the beds available were finite — it was unlikely that medicine could obtain more at the expense of another department. It was therefore important that not only should there be a planned system established for the recruitment and appointment of geographic full-time clinical staff but that there must also be control exerted over the appointment of part-time staff in the interest of the academic objectives of the department. It was recognized that a part-time staff member was dependent on his practice for his livelihood, and that he would necessarily require more beds than his geographic full-time colleague. When director of the division of Cardiology I had already given thought to this matter, and as a division we had agreed to approximately a 3:1 bed ratio for each part-time to G.F.T. staff.

It was agreed within this committee, and later by divisional directors and the Department of Medicine University Hospital, that part-time staff appointments would be subject to selection committee procedures similar to those for a G.F.T. position.

At the meeting of the committee on January 13, 1970, Dr. Cameron, the Associate Dean, attended to explain the various types of appointments which

could be made -- G.F.T., full-time, major part-time, and part-time. Although it was a recognized that new appointments might have to be supported through soft funds the committee concluded that the department required a "core" of 20-30 G.F.T. staff.

In the meetings between April 7 and May 26, 1970, the committee discussed the matter of professional earnings and the then current regulations as applied by the Board of Governors of the University. The ceiling for professional earnings in the most recent year (1968) was $12,500. The average professional earnings was $8,828 and the median $3,703.

The committee agreed that a ceiling was desirable; that excess earnings of the faculty should be distributed to the Dean's office and to all departments (the proportions being open to discussion); and that there be some form of equalization payments to "poor divisions." They proposed that there be a relationships between ceiling and the net average earnings of physicians practicing in Alberta such that the ceiling would equal the net earnings of the Alberta practitioner, reduced by the initial salary of an Assistant Professor and any market supplement.

The conclusions of the committee were summarized in a position paper for the department which I prepared and forwarded to the Dean (See Appendix A). No further action took place until the department explored ways of establishing a departmental practice plan in 1972, an unsuccessful venture which will be described later.

"COMMITTEE" OF WARD CHIEFS

Another administrative committee had existed in the University Hospital since early in Don Wilson's chairmanship. This was the committee of "Ward

Chiefs" which met irregularly. It really did not function as a committee but rather as a number of individuals, each responsible to the Chairman of the Department of Medicine of the University Hospital for the smooth functioning of a ward. They were as often as not, persons other than the divisional director. The first minutes which have been retained in the department are dated December 16, 1967; those attending that meeting were Wilson, McLeod, Little, Dvorkin, Elliott, Monckton and Kidd. In the course of 4 meetings which were recorded between then and 1969, matters discussed included the recurrent problem of ward labs and teaching space; a decision requiring each resident in medicine to spend a full night on emergency call as "back-up to the intern"; the designation of beds for patients of the Family Clinic on Station 31 and a future request to the Chairman of Surgery (R.A. Macbeth) to accept a share of this responsibility to the Family Clinic with medicine; and a conclusion that the education value O.P.D. clinics "has reached a low ebb."

The Ward Chiefs continued to function throughout my term of office, performing an essential task, often frustrating and certainly unrewarding in any material nature. The gradual reduction of beds, the increase in attending staff, the changing and additional responsibilities for undergraduate education all added to the burden shouldered by these loyal staff members.

As the department grew, communication increasingly challenged the chairman and his administrative officer. When I sat on the other side of the fence, while Don Wilson was chairman, I remember Gordon Kerr asking me what he, as a newly appointed administrative officer, should do for the department. My answer was "to interrupt the flow of memos". In the intervening years the problem has not lessened but has been amplified by the ready availability of the "xerox", a machine beloved of the secretaries who no longer make carbon

copies but merely push the button to produce innumerable copies to be distributed far more widely than good sense would dictate. I found no answer to the uncontrollable increase in information transfer!

DEPARTMENTAL MEETINGS

In an attempt to reduce the amount of circulating paper I used hand written memos when I sensed that filing by the recipient was unnecessary. More formal transmissions were generally made to staff through the divisional directors. Finally, the announcements of general interest were made at the monthly meetings of the Department of Medicine of the University Hospital. These were held immediately after one of the weekly Grand Medical Rounds and usually lasted from noon to 12:45 p.m. These were supplemented four times a year by meetings of the whole department of the faculty, held in rotation at the various constituent hospitals. At both of these meetings the members of the department quite properly felt free to put questions and problems before the chairman, an arrangement which enhanced the democratic process but which on some occasions left the chairman somewhat exposed and vulnerable.

THE NEW CURRICULUM

The events which led up to the introduction of the new curriculum have already been discussed. The first class entered the first year of the new curriculum in September 1969. The first year consisted of Period I and IIA. The development and co-ordination was the responsibility of what was then called the "Fundamental Basic and Clinical Sciences Program Committee" chaired by Dr. Bill Paranchych of Biochemistry. Two members of the Department of Medi-

cine (Little and Watanabe) sat on this committee. The courses listed for Period I were Gross Anatomy, Microanatomy, Embryology, Physiology and Biochemistry. Period I was, indeed, still departmentalized and when the courses from Period IIA were added (Pharmacology, Bacteriology and Pathology) it was difficult to recognize the content as different* from the curriculum it was replacing. The only new course was one in Behavioral Sciences and Social Medicine.

In April 1970 the Medical Students Association produced a document entitled "Student Opinion of the New Curriculum". In this they discussed each stated objective of the new curriculum and concluded that the Curriculum Advisory Committee "has failed to implement a new curriculum in accord with the objectives of the C.R.I.M.E." (Committee on Research in Medical Education). They believed that the Curriculum Advisory Committee had failed to "completely radicalize the curriculum". This concern applied particularly to what they saw as only a minor manipulation of assigned teaching hours among the departments. The faculty too had concerns about the new curriculum and at the Faculty Council meeting on February 26, 1970 the minutes read "In discussion consideration was given to the possible effects of current budget restrictions on the new curriculum, possible conflict of duties between graduate and undergraduate interns, and the possibility of reducing the number of examinations."

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*Dr. Kling's report to Faculty Council of March 19, 1969 claimed a "considerable decrease in assigned teaching time and co-ordination between the various courses." There was also meant to be the introduction of clinical material into the various basic sciences. Radiology was introduced into first year teaching, integrated with gross anatomy.

At the May meeting (1970) Council agreed to substitute a Student Evaluation Board for the former Committee on Examinations. The membership consisted of the chairman of each of the three Phase Test Committees, the Associate Dean (Undergraduate Affairs) and the Director of Graduate Medical Education, with four students representing the medical undergraduates.

The new curriculum was expected to provide sufficient free time to permit the student to pursue independent study. This was to be complemented by the electives program which allowed the student to study a topic of his choice in depth. The students described the elective program in Phase III as the most commendable aspect of the new curriculum, but were concerned that this had been accomplished at the expense of electives in the first two years, thereby introducing rigidity into the first half of the program. They also argued that, contrary to the claim of the Curriculum Advisory Committee for an increase in clinical content, clinical experience in the first two years had been further reduced.

The Student Association acknowledged that the Committee on Research in Medical Education had recommended that grades be de-emphasized but pointed out that examinations in Phase I had been increased so that they now averaged one every eleven days. They deplored the reluctance of the faculty (and admittedly many students) to accept a Pass-Fail system which they (Student Association) believed would reduce the "power that each individual department would have over the student" to insist on mastery of non-core material.

Finally, the Association concluded that the new curriculum was offering nothing to help students respond to the changing needs of society. No changes had been proposed for selection of students, marks remaining the sole criteria for admission. There were no changes in emphasis from treatment oriented instruction to the teaching of preventive medicine.

The Student's Association was skeptical that the laudable objectives could be maintained "when the impetus to change has waned and the new curriculum has become the established curriculum." They lamented that the deficiencies they identified in the new curriculum suggested the presence of "certain powers structures and philosophies" in the medical school which would continue to frustrate those trying to bring about change.

The students, idealistic, impatient, but genuinely concerned and thoughtful, were disappointed by the new curriculum and perhaps disillusioned in the processes followed by the faculty in trying to pursue worthy objectives. They saw the medical establishment as stodgy and conservative with a "reluctance to let go of the past".

I and all other clinical department chairmen sent written commentaries to the Dean concerning the students' submissions. I had agreed with many of the students' observations. He responded by cautioning me that we had to walk before we ran and that the curriculum would be studied and improved annually.

The student reaction was important to the Department of Medicine. Our department was responsible for 300 of the 400 hours of instruction in Phase II. The task was the more difficult because in the new curriculum Phase II was designed as a series of systems and the responsibility for teaching did not rest administratively with the department but with the Phase II committee. As described earlier, Phase II was "de-departmentalized" and this left the administration of the department with the uncomfortable feeling that the department through its members had a major responsibility for Phase II without a clearly defined authority.

The new curriculum continued to present problems to us throughout 1969-74 in that changes had to be made because of our deficient resources - and with

each expediency it became more difficult to pursue the original objectives so bravely introduced in 1968-69. For instance in the report of the Curriculum Advisory Committee to Faculty Council, February 26, 1970, it was stated that the matter of history taking and physical examination appeared to have been overlooked in the original report of May, 1968. Brian Sproule was appointed chairman of a sub-committee established to remedy this omission. The solution resulted in the introduction of video-tape sessions and small group teaching at the beginning of Phase II, followed by examination of patients by small groups of students under faculty direction throughout the rest of the year. Additional experience was added in psychiatric interviewing and in ophthalmologic examination, but neither of these used resources from our department.

The University of Alberta, Faculty of Medicine Newsletter* in 1969 was devoted to a justification of the new curriculum and a description of it. Second year was described as the bridge between basic sciences and clinical medicine. The intention was that body systems would be taught by "teams consisting of basic scientists and clinicians working together", a goal which was never really attained. Integrated teaching was to be done in small groups, an unrealistic objective for a full-time and geographic full-time faculty totalling 96 in 1968-69.**

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*Faculty of Medicine Newsletter, Number 3, 1969.

**The ratio of undergraduate students to faculty was 4.2 at the University of Alberta, Faculty of Medicine, contrasted with an average in the United States of 1.6.

The second year proved, in time, to present a heavy load to the students despite the promise of 135 hours of unassigned time "during which students may engage in electives of their own choosing."*

The continuum of third and fourth year in what was called Phase III** consisted of 50 weeks of clinical experience and 32 weeks of electives, the latter constituting what probably was a North American record. Like Phase I, Phase III was in effect, taught in a departmentalized manner. The stated intention of the planners of the new curriculum was that students would serve in the same capacity as the traditional rotating intern. For this to be successfully brought about it was necessary that clinical teachers responsible for the first rotation of these students, be it in surgery, medicine or any other department, recognize the deficiencies of these products of Phase II of the new curriculum. They had not mastered the skills of history taking, physical examination and venepuncture. Teaching staff, especially in the affiliated hospitals, were not well enough informed about the changes wrought by the new curriculum and became impatient with and resentful of what they considered to

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*Faculty of Medicine Newsletter, Number 3, 1969.

**The lack of agreement among medical educators with respect to length (as well as content) of undergraduate medical education is well illustrated by the observation that in 1968-69 Saskatchewan and Laval introduced a five year curriculum as did Montreal in 1969-70, while McMaster began its three year, year-round curriculum. (From Medical Student Enrolment in Canada, 1969-70: Report of statistics. Collinshaw N.E. and Grainger, R.M. Canad. M.A.J. 104: 916-922, 1971).

be inadequately prepared student interns. Reference is made to this matter now in order to provide explanation for problems which will be discussed later. The new curriculum and its introduction were again explained in the report of the Curriculum Advisory Committee to Faculty Council in September 1969.* The phasing out of the old program began with the students in third year as of September 1969. After a modified third year finishing in March 1970, this group of students began a special contracted period (Phase IV) on April 23, 1970. Those students entering second year in September 1969 also had a modified second year and modified Phase IV. It was not until the summer of 1971 that students who began in 1969 entered Phase III of the new curriculum and the full effect of change fell on the department.

GRADUATE TRAINING PROGRAM

In 1968-69 the Royal College of Physicians and Surgeons of Canada adopted more formal procedures for accreditation of graduate training programs. The concept of 2 core years of training followed by a less structured two years, all integrated into a University supervised program was adopted, and training programs sponsored by hospitals were no longer accredited.

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*The Chairman, Sam Kling, was exaggerating somewhat when he stated in his report "The Faculty have accepted the new curriculum with great enthusiasm .....". There were some of us who worried that we did not have a staff large enough to implement the small group teaching, a fundamental concept of the proposed changes. This was a particularly worrisome problem when one recognized the strain to be put on our resources by the repetitive presentation to small groups throughout the whole of Phase II.

Our Faculty Council agreed to the establishment of a Division of Postgraduate Medical Education in which all graduate trainees would register after October 1969. In December 1969, Dick Rossall, Assistant Dean, Graduate Training drew up the necessary documents for submission to the Royal College to permit the Royal Alexandra Hospital to offer parts of core and non-core programs. Two years of core training was approved in January 1970.

Accreditation of the Faculty had taken place in the spring of 1969. An abstract of the report, as applicable to the Department of Medicine was sent to me by Dean MacKenzie in January 1970. In my reply of January 26, 1970 most of my comments related to the relationship of the Family Practice Clinic to the Department of Medicine. Stations 31 and the Mewburn Pavilion (MP2) had become, in the re-organization of all the stations to provide specific ward homes for the newly designated members of sub-specialty divisions, the home wards for General Internal Medicine. It seemed reasonable to me that the Family Clinic should be able to admit their patients to a specific area and that the most logical conjunction would be with General Internal Medicine. In return, the members of the Family Clinic agreed to share responsibility of a rotation for admitting patients without a personal physician from the Emergency Department. We thought this arrangement might also provide a source of patients for our residents who were not getting enough responsibility for patient care. In addition we hoped it would improve our teaching program in the undergraduate student internship.

In the same letter I informed the Dean that while all undesignated patients would be admitted to a member of the staff in General Medicine or the Family Clinic rather than to a roster of sub-specialists, there still remained a problem of finding someone in general practice to provide continuing care

after discharge of these patients. I hoped to interest two or more competent family physicians in general practice in becoming associated with our department. In return for accepting such patients for continuing care, they would have the opportunity to take part in the ward rounds and teaching before such patients were discharged. Our resident staff were expected to take major responsibility for such patients both in the hospital and on their return to the outpatient clinics until the conclusion of care required by their presenting illness, after which the family practitioners would take over. I hoped that such an arrangement with family practitioners on the southside might, in addition, result in referrals to members of our Division of General Medicine. We were unable to arouse sufficient interest among nearby family doctors or support from our own staff to introduce this plan. It was probably not sold skilfully enough.

Affiliation agreements were concluded with the Charles Camsell Hospital and with the Department of National Health and Welfare in 1969. The first of these formalized our relationship with a hospital which had provided important clinical opportunities since the end of World War II for our undergraduate students, but which would soon have graduate trainees as well. Dr. Ken Martin, Chairman of Pediatrics, was nominated by the Dean to represent the Faculty on the Board of Management of the Camsell Hospital. The second introduced an interesting new type of experience for both graduate and undergraduate students in the Northwest Territories. Graduate Trainees and students were to be sent for part of their training to Inuvik from which they might also visit outlying Nursing Stations. This program in a modified form has continued until the present time.

In the fall of 1969, Dick Rossall, Assistant Dean for Post Graduate Medical Education, asked for a nominee from the Department of Medicine to a new committee, an Advisory Committee for Post Graduate Medical Education, and Jack Sprague was asked to serve.

HOUSESTAFF DISCONTENT

During 1969 the housestaff in the Province had begun to organize as a bargaining body and in 1970 they formed the Professional Association of Interns and Residents of Alberta. Despite the earlier lack of a formal organization, salaries for housestaff had increased 100% between 1964 and 1969. In July 1969 the annual stipend for an intern was $5,200 increasing by steps to that of a Resident IV who was paid $7,500. In their brief, they asked for $6,200 for an intern and $10,000 for a Resident IV. At that time their group claimed that 57% of their members were moonlighting to pay off debts. An argument of some persuasion was that they were being paid $2,400 less than comparable housestaff in Ontario or British Columbia, despite the increase over recent years.

The Department of Medicine, through its divisional directors, prepared a response to a brief from the housestaff received in January 1970. In addition to the salary demands already referred to, the housestaff were asking for 4 weeks holiday, subsidized car parking, private rooms when on call, laundry for uniforms, time off for statutory holidays and paid malpractice insurance. Housestaff throughout Canada had begun to organize in provincial associations in 1969-70 with the object of improving not only their pay, but also their working conditions, fringe benefits and the quality of instruction. That they

should become vocal and adopt what some senior faculty members looked on as "labour tactics" to bring about change was not surprising when one recognized that these men and women were undergraduate students of the sixties.

A leading article in Lancet (625, March 23, 1968) was entitled "Revolting Students" and put forward two explanations for student unrest: the adolescent need to rebel and the aspects of society generally or specifically which provoke rebellion. Although some of the housestaff of 1969-70 thought that such matters as dress code were unimportant and objected to the imposition of the standards of others, I believe that the majority of our residents focussed their demands on those matters which they believed should be corrected in order to provide them with an appropriate opportunity to train in their specialties. Ideally, as stated by the writer of the leading article, "...willingness to exchange views on the basis of mutual respect can make the confrontations both productive and truly educational."

The World Medical Journal (Vol 16:p.73, 1969) used an editorial to introduce one of their bi-monthly issues which was planned around the medical student rather than the medical educator or curriculum. They recognized in doing so, the breaking down of the authoritarian tradition which separated the student from those who planned the curriculum and taught him. Those barriers have never again been erected.

Our staff, as represented by their divisional directors and recorded at a meeting on March 7, 1970, were sympathetic to most of the demands made by the Housestaff in their 1970 brief and replied with suggestions about how their presentation might be made more convincing. (Negotiations were being carried out between the Housestaff Association and the Alberta Hospital Association). In his memo on April 3, 1970 to Department Chairmen and Divisional Directors,

Dr. John Read stated that government would not increase the total amount for stipends ($905,000 in 1969-70).

Plans were made to reduce the number of interns and residents in the Department of Medicine in 1970-71 from 38 to 34 (28 in General Medicine and subspecialties other than Neurology which would continue to be allotted four). The Housestaff sought to go forward with one of their complaints (which had to do with their working week) to the Provincial Minister of Labour, charging unfair labour practices by the Hospital, and stating that it was illegal to have an employee work more than 48 hours/week. This complaint was refused by the Inspector of that department as was their request for permission to sue for overtime.

In a letter to Dr. John Read, Vice-President (Medical) on June 4, 1970, I wrote that the situation with respect to the residents was becoming urgent because of the combined effect of reduced and insufficient positions and too few applicants to permit selection of good candidates. In the previous fall, we had only 24 applicants for 22 positions in general medicine. There were an additional eight associate residencies allocated to the subspecialties and by the spring one incoming resident had been signed for each of Hematology, Rheumatology, Cardiology and Gastroenterology. None was signed in Endocrinology or Pulmonary Diseases. Nephrology contracted two. Of the fifteen residents who signed (leaving a deficit of seven Housestaff) six were seconded to and paid through the affiliated teaching hospitals -- Royal Alexandra, Edmonton General and the Misericordia -- leaving only nine in General Medicine at the University Hospital.

The anxiety of the Housestaff concerning the quality of training which would be available and their resentment over what they saw as the indifference

of faculty and hospital administrators to their concerns led to a series of demands presented to the Department of Medicine in June 1970 with a deadline of June 17 before which time they expected "satisfactory solutions" to some eight matters.

At about the same time, we had been informed that our allotment of positions for residents had been reduced from the former establishment of 34 to 28. Neurology had somehow established a separate quota of four residents and this was unchanged.

The demands of the Housestaff concerned their nights on call, the number of residents available, and the nature of the work they considered appropriate. They also expected to be consulted before any changes were made which could affect them. In addition, they had several complaints about the teaching.

At an urgent meeting of Divisional Directors which was called for June 12 it was apparent that at least some of the support which had been generated among the staff for the brief put out by the residents in January 1970 had dissipated because of the demanding nature of their approach in June and their threat to resign if their conditions were not met by their stated deadline of mid June.

With the support of Jack Sprague, Director of Graduate Training Program and Gordon Kerr I persuaded them that we were trying to reach reasonable and fair solutions to some acknowledged problems but pointed out that we were faced with inadequate numbers of residents to accomplish what we all agreed needed to be done in the University Hospital and the three other affiliated hospitals. Dr. Regina Donnelly accepted the difficult task of Chief Resident for the 1970-71 academic year and we settled in to an uneasy truce.

It was ironic that we should be faced with demands by the residents for nothing more onerous than one night in three on duty and relief from writing discharge summaries while at the same time that we found it necessary to ask Drs. Rossall and Little at a meeting of Divisional Directors to establish guidelines for moonlighting by residents. This took place in Emergency departments in the city hospitals and at the W.W. Cross Cancer Institute where moonlighting residents were employed to write histories in the evening on newly admitted patients.

THE FACULTY

RECRUITING NEW STAFF

Despite the depressing forecast of few if any new positions for the faculty, each Divisional Director was encouraged to plan for the expansion of his division. The Advisory Committee (Long Range Planning Committee) supported me in providing the Dean with arguments to establish our department's priority for new positions within the Faculty and information with which we hoped the Dean could advance the Faculty's requests of the University. Any of us who had much to do with the rest of the University community realized how little our colleagues from other faculties knew about us. Some thought that all those practicing in the University Hospital were salaried staff; others believed that all patients coming to the University Hospital were allotted in rotation to attending staff; the majority had little concept of the need for full-time teachers in our Faculty and even less appreciation of our deficiency when compared to many other medical schools. I tried at every opportunity to explain our needs to those outside our faculty but the impression persists to

the present time in senior administration and bodies such as Dean's Council, that our Faculty is doubly blessed through our relationship with the Department of Advanced Education and the Department of Hospitals and Medical Care, and that we have more than our share of all good things.*

At the beginning of the 1969-70 academic year efforts were being made to recruit several new staff. Offers were made to Eliot Phillipson to return to the Division of Pulmonary Diseases and to M. Davidman to join Alan Gilbert at the Royal Alexandra Hospital. Eliot chose to go to the Toronto General Hospital and another former student and potential recruit, Dr. Henry Mandin, who was in Dallas, declined an offer to return because we were unable to arrange for a geographic full-time salary, a result of the freeze on appointments imposed by the University administration. More success attended efforts to find a third person for the Division of Gastroenterology. Fred Weinstein, a Manitoba graduate joined us after completing graduate training in Seattle in the summer of 1970.

For the next five years, the Divisional Directors made every attempt to find salary sources for positions for which there were no geographic full-time salaries. Although this was an essential expedient if we were to expand, it was one for which we paid a price by creating ad hoc arrangements which appeared to establish geographic full-time positions, but which did not. Over the subsequent years, the belief that people supported through various soft-

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*Since the Alberta Heritage Foundation for Medical Research initiated its program in 1980 our faculty has benefitted more than any other part of the University through this additional source of research support.

funding arrangements were entitled to the fringe benefits of University staff has given rise to bitterness and dissatisfaction. The soft-funded faculty member has been expected to meet the obligation of any geographic full-time member yet he has had no sabbatical leave, no pension and often no subsidized health care or insurance, all of which were benefits of his colleagues on hard funding.

The Divisions of Cardiology and Respiratory Diseases had for sometime made use of pooled professional earnings (soft-funding) to attract additional staff to cope with an expanding clinical load. The University Hospital also recognized that it was sometimes impossible to staff certain services through the staff of part-time (private practice) or full-time University faculty.

One of the first needs in this category was in the developing specialty of intensive care. Dr. Garner King (who returned in the fall of 1970) had gone to Denver for training in this subspecialty. In November 1969, Dr. John Read and I corresponded about the terms of reference for his appointment. I was concerned about the description of his administrative position as embracing "the type of freedom that would be equivalent to a department head", and also with the suggested arrangements for professional earnings. I saw the former as creating problems in the relationship which he might have with the Division of Respiratory Diseases (in which he would hold an appointment) and for the Chairman of Medicine in the Hospital.

In the next five years the differences in philosophy between the hospital administration and some of us with faculty responsibilities continued to surface. We were never able to persuade the Hospital that the teaching faculty might "contract" to provide professional services in such areas as intensive care, coronary care and renal dialysis. Dr. Snell saw an obligation for the

Hospital to provide such professional services through and under the direction of the Medical Vice-President. In effect we had two Departments of Medicine, one the responsibility of the Chairman of the Department of Medicine, of the University Hospital (who in turn was responsible to the Medical Vice-President) and the other a disparate collection of physicians whose terms of appointment, authority and salary were primarily the responsibility of the Medical Vice-President, University Hospital.

The hard facts which had to be faced were that the University was unable to provide our faculty with the necessary funding to increase our academic staff to a level at which we could effectively argue professional matters with the Hospital; that the Hospital plainly had an obligation to see that professional services were provided in several areas of new development; that these were "service" tasks and the Hospital was able to fund them through the Department of Hospitals and Medical Care. From a pragmatic viewpoint, I saw that the only way to support a reasonable number of new staff was to try to work out mutually satisfactory arrangements with the Hospital, and I think this was largely accomplished. Several members of our department continued, through my term of office, to harbor resentment over these arrangements but no better solutions were ever suggested.

At the beginning of the 1970-71 year, Dean MacKenzie told me that the whole Faculty - Basic and Clinical departments - would have five new positions available. Of these our Department was allotted one. The tight budget promised by the President was quite evident.

Dr. Harvey Whiting, Chief of Medicine at the Royal Alexandra Hospital asked for three additional full-time staff and Drs. Sam Weiss and Preswick spent an evening explaining to me that they needed leadership from a "force-

ful" geographic full-time staff member at the Misericordia Hospital which they complained was not being adequately supported. At neither hospital were there any well developed plans for initiating academic departments but my pessimism concerning the possibility of providing even a single person at either hospital was greeted with disbelief.

CHAPTER III

THE WORLD AROUND 1970-1971

The preceding academic year had ended in May 1969 in the United States with the tragic student deaths on the campus of Kent State University. Learning was suspended across that country when four hundred colleges went on strike by the beginning of the following week. We lived next to a country whose influence we could not escape, a country whose Senate expressed the guilt of the nation over the death of more than 40,000 young soldiers in Vietnam; whose students rose in protest against their national leaders; whose citizens began to recognize the reality of pollution; whose opposition was expressed in the violence of the Weatherman's bombs as well as the Black Panther's hate. By June 1970 the National Institute of Mental Health estimated that more than 20 million Americans had experimented with the use of street drugs. Inflation, which first victimizes the unorganized and the weak, began to threaten the life-style of the middle-class.

Canada could not, did not remain immune. October, 1970 saw the kidnapping of three officials and the murder of one (Pierre Laporte) by separatist terrorists of the FLQ in Quebec. Mr. Trudeau responded more firmly than had President Nixon, by the imposition of martial law through the Wartime Measures Act (October 16, 1970).

Linus Pauling, Nobel prize winner in Physics, intruded into medicine by claiming that large doses of Vitamin C could ward off the common cold. An assailant attempted to assassinate Pope Paul VI in the Phillipines. Canadian

unemployment reached 6.6%, the highest rate since 1961 and the dollar was allowed to float, 92.5 to 92.8 cents U.S.

By 1971 Theodore White concluded that the upheavels we had been going through characterized the end of the Postwar World. The trade balance turned against the U.S. and to stem the dollar crisis the U.S., the last bastion of gold-backed currency, ceased to redeem its dollars with gold. Rolls Royce declared bankcruptcy. Kidnappings and bombings continued. The Prime Minister married Margaret Sinclair and the federal government conference completed drafting a proposed constitutional charter.

Appollo 14 landed on the moon despite engineering problems and Britain adopted decimal currency.

The medical world lost Lord Boyd-Orr famed nutritionist, Herbert Evans, the anatomist who discovered Vitamin E and isolated growth hormone, Bernard Houssay, Nobel Prize winner in Physiology, Sir Alan Moncrieff of the Hospital for Sick Children, Great Ormond Street and W. Stanley, Nobel Prize recipient for his work in viruses.

In medicine the enthusiasm attending the survival of the first patients treated with heart transplants gave way to sober consideration of organ preservation and better prevention of rejection. The introduction of L-DOPA gave hope to patients with Parkinson's disease but concern grew over the speed with which bacteria could develop genetic changes to resist antibiotics. Electrophysiologic studies were introduced into clinical cardiology and the longevity of pacemakers was enhanced by the use of nuclear power packs. Prostoglandins became the centre of interest to endocrinologists, more was understood about neurohormones and T3 thyrotoxicosis was recognized.

While several American medical schools struggled to avoid bankruptcy, the Association of American Medical Colleges recommended preparations to train 50,000 more doctors by the mid-1980's through expanded classes and the funding of twelve new medical schools. So much for the ability of our health care and educational experts to forecast the needs of this currently over supplied decade of the eighties!

THE ACADEMIC YEAR 1970-71

THE FACULTY

THE DIVISION OF GENERAL MEDICINE

At the end of June, I was surprised and disappointed to receive the resignation of Gerry Richards. He had organized the undergraduate teaching, the residency program in general medicine and the wards assigned to general medicine quickly and to the satisfaction of students, residents and staff. In his practice at the Royal Columbian Hospital, New Westminister, he had indeed worked as a general internist. He did his own invasive diagnostic procedures and was unusually self-reliant. In the University Hospital he found several divisions of sub-specialists, each trying to establish rights to specific diagnostic procedures. Gerry saw the territory which he was used to occupying as a general internist being eroded on several sides by the tide of developing subspecialists. He made his choice to join them, returning to Vancouver to qualify in Nuclear Medicine which he has since practiced in Victoria.

Despite my disappointment at losing our first full-time Director of General Medicine, I remained firm in my conviction, not shared by a number of colleagues, that it was essential to build a strong division to act as a basic

support for all the sub-speciality divisions. I emphasized in a letter of November 19, 1970 to the Dean, our need to retain and fill the vacancy created by Gerry's resignation, and obtained his support. The difficulty in finding suitable candidates was evident in the discouraging responses to my letters addressed to other Chairmen of Medicine across the Country. It would not be until 1972 when Dr. L.M. Anholt joined our staff that the full-time position was again filled.

OTHER STAFF CHANGES

In October 1970 Drs. Ludwig Sherman of the Royal Alexandra Hospital replaced Dr. Eidem of the General Hospital on the Advisory Council and Dr. Alex McPherson replaced Dr. Watanabe. At the first meeting in the fall, the Committee discussed the collection of data concerning the teaching contribution of our part-time staff. This was to enable me to allocate more fairly our limited funds and to encourage those who continued to teach willingly and enthusiastically, despite their sacrifice of time. Many members of our part-time staff fulfilled heavy clinical teaching schedules; a few were continuing to draw stipends inappropriate to their current responsibilities. After we completed a redistribution of stipends, the latter usually retained their rank with no stipend, an arrangement which left them with University affiliation and the privileges of the Physical Education facility and the Faculty Club, matters of no small importance to them.

On September 28, 1970 President Wyman informed all faculties that no hiring of staff for new positions or replacement staff for vacant positions would be permitted until further notice. The divisional directors had by now recognized that the Dean was unable to keep his promise of the necessary additional

full-time staff which he had made at the initiation of the new curriculum. For the next three years they managed to increase their numbers by producing basic salaries from special service programs, professional diagnostic or interpretive fees, and pooling of professional income. In a survey which I later carried out from the Dean's office, I estimated that the Faculty GFT Clinical Staff contributed approximately a million dollars a year from professional earnings to support research and teaching.

During the 1970-71 academic year three new members joined the Department. Dr. Garner King, a graduate from Alberta in 1963, joined the Division of Pulmonary Diseases after additional graduate training at the University of Colorado in Denver in intensive care medicine. He was appointed by the Hospital to a salaried position with the funds coming from the accounts submitted by the Hospital on his behalf to the Alberta Health Care Commission, with additional small contributions to his salary from the Faculty of Medicine and the Hospital. Other aspects of his appointment have already been discussed. He initially had no admitting privileges outside the Intensive Care Unit but later was granted all the priveleges of the active staff. Garner has borne the responsibility for developing the concept of general intensive care in the University Hospital and with the support of Dr. Sproule has built a national reputation for both the high standard of professional care and the excellence of the post-graduate training program.

We, together with the Department of Pharmacology, recognized a need for someone to practice clinical pharmacology and to initiate research in this rapidly developing area. We were unsuccessful in our attempt to attract Dr. Dennis Schneck back from the United States where he had gone for further training. We had thought that support might be obtained if he developed a program

applied to the non-medical use of drugs, a matter of public concern in the early seventies.

The Division of Neurology in 1970 consisted of one geographic full-time member, Dr. George Monckton, appointed in 1957, and two others supported from research funds and practice (Dr. T. Nihei and Dr. G.J.G. Blain). A selection committee in 1969 selected Dr. Don McLean to fill a void in neuro-electrophysiology. Dr. McLean, a graduate of the University of Manitoba (1960) had taken post-graduate work at the Montreal General Hospital and from 1966 to 1969 had been at the Harvard Neurological Unit.

Dr. McLean accepted an appointment as Assistant Professor in the Division of Neurology, July 1, 1970 to develop clinical neurophysiology, to accept responsibility for the ECG laboratory and to take part in the teaching program. As was the case with so many appointments in those years his salary was made up from three sources with the smallest contribution coming from the Faculty. The major part was obtained from the professional fees accruing from the interpretation of electroencephalograms with the third part coming as a Faculty of Medicine supplement from the University.

Such arrangements were not ideal but they constituted the only pragmatic solution to the problem of trying to attract new staff. There was little reason to hope for an early improvement in finances of the Department, and one's pessimism was unrelieved by messages from the office of the Dean. In negotiations with Don McLean we had voiced our hope that a geographic full-time position would eventually become available to Neurology for Dr. McLean. Dean MacKenzie was usually quick to correct any comments which he was unable or unwilling to support and I received a copy of his letter to Dr. Monckton in which he brought us back to reality with the statements that " ---there is no

obligation for the University to assume responsibility for paying his (McLean's) basic salary." and "Dr. McLean will in all probability be dependent on EEG funds for a considerable number of years." And indeed he was!

The Division of Gastroenterology, in plans submitted to the Long Range Planning (Advisory) Committee in the fall of 1969, made a strong plea for a geographic full-time appointee by 1970-71. The Dean told me that for budget year 1970-71 one new position would become available to our Department. He emphasized the fact that he had managed to get only five for the whole faculty (15 departments). I repeated the arguments I had used the year before and would continue to put forward over the next three years — namely that it was the clinical departments who were badly understaffed by national standards and among the clinical departments it was Medicine which bore by far the heaviest load. In fairness to the Dean, I should record that in his report to Faculty Council for 1970-71, he described the difficulty in filling clinical positions and attributed the problem to inadequate salaries and a "shortage of hospital and support facilities."

We were pleased to learn in the Spring of 1970 that Dr. W.M. Weinstein was prepared to accept an offer to join the Division of Gastroenterology in July 1970. Fred Weinstein graduated from Queen's in 1964, did three years of residency in medicine at the Royal Victoria Hospital, Montreal and then spent three further years in gastroenterology in the Department of Dr. Cyrus Rubin in Seattle. His research interest was intestinal cellular kinetics and the terms of reference of his appointment as a GFT member of the faculty were that he spend 50% or more of his time in research with the remainder divided between teaching and patient care.

Dr Weinstein developed a productive and well-supported research program and established a model of co-operation with members of the Department of Pathology with whom he conducted weekly joint sessions devoted to the interpretation of intestinal biopsies. He fulfilled the prediction of Dr. Rubin by excelling in each field of his endeavours - being recognized by the students as Teacher of the Year, quickly attaining recognition as an original contributor in research and becoming a full professor by 1977. The Department was sad to lose him to the University of California in Los Angeles in 1979.

In the fall of 1970, there were twenty-eight staff members in what might be considered "GFT" positions. Of the twenty-eight no less than sixteen had non-University sources of salary and the problems created by "soft-funds" looked as if they would persist indefinitely.

Dr. T. Nihei, a research biochemist, joined Dr. Monckton with support from the Medical Research Council in the development of a laboratory devoted to neuromuscular research. As Nihei's MRC Scholarship approached its termination, Dr. Monckton sought alternative sources of support without success. This introduced us to the difficulty of trying to establish departmental priorities with respect to the inadequate number of hard-funded positions, while at the same time encouraging divisional chairmen to recruit researchers through support of the MRC and the voluntary health agencies. The directors knew full well that at the conclusion of anytime from three to six years, such people might no longer be eligible for personal support from the agency, but it was impossible to promise them a University position with hard funds. Dr. Nihei's contributions were valued by the Division of Neurology and he was both respected and liked by other members of the Department. Although Neurology did not enjoy priority with respect to the next available position, the Advisory Com-

mittee and the Divisional Directors agreed that Dr. Nihei should be offered a full-time position. This was done and he continued in his quiet and productive research career until his tragic illness of 1984.

Some voluntary agencies with programs for support of personnel in research had established policies which required the institution to make a commitment to take researchers on to full-time staff at the conclusion of their fellowship or scholarship. The agencies believed, with justification, that they were providing the seed money to establish a young person in a career. If he proved to be a successful researcher they believed that the institution should be prepared to add that person to their staff. This was not always easy to bring about!

This and other problems were brought for description and discussion to meetings of the Department, held monthly for staff at the University Hospital and twice a year for the members of all affiliated teaching hospitals.

PROFESSIONAL EARNINGS

Dean MacKenzie established a Review Committee on Methods of Remuneration consisting of all Chairmen of clinical departments. Although there had been periodic discontent with the system of controlling professional earnings through a soft ceiling, established and irregularly reviewed by the Board of Governors of the University, this plan had stood up reasonably well since 1955. I believe the Committee made no significant recommendations - at any rate no changes were introduced.

In the Department of Medicine we introduced more formality into the dispensation of the departmental share of excess earnings. The appropriate use of these monies was described as follows:

1. To support travel to meetings or courses or to learn new techniques or research methods.
2. To support visiting professors.
3. To provide training for non-academic or technical staff in techniques essential to research and development.
4. To support activities of the Residents including travel, the purchase of library books and other items relevant to their training.
5. To support the clinical staff in any projects of broad departmental interest.

Because the Department was not guaranteed minimal annual deposits to this fund it was considered inappropriate to make any committment to the support of personnel except for short finite periods. Taxation Canada looked at several medical schools which had practice plans, and expressed their opinion that all earnings must generate a tax. Throughout the years we in this faculty never had more than an "understanding" with the local Income Tax Office that clinical earnings paid as "excess" to the University would be deductible before tax.

I was determined that we would not be put in a position as a Department, in which we could be accused of laundering clinical earnings (which I believe was done at some other institutions). We therefore, never made travel funds available from Excess Earnings to anyone who had made contributions to this fund. It made little sense to grant such a request and accompany it by an income tax T form ensuring that it then be declared as income. Such a policy, in addition to keeping us in a safer relationship with Taxation Canada also permitted the committee to be relatively generous in providing travel funds to our part-time staff who ordinarily had no other source to which they could turn. The Departmental committee overseeing this fund functioned rather infor-

mally but had appropriate representatives in the persons of the Associate Dean (Dr. Cameron), the Administrative Officer of the Department, myself and two members of the clinical staff (Dvorkin and Crockford). It was helpful indeed to have a discretionary fund although I constantly reminded myself that if we had more clinical staff to bear the load and each person worked only to the "ideal" clinical limit, the funds would not, or should not exist.

In 1970-71 the Excess Earnings* provided a total of $13,730 to support travel, temporary secretarial help and equipment - a modest but useful addition to our budget. A wise investment was to equip the laboratory of Dr. Fred Weinstein. The dividends were referred to earlier in this paper.

TEACHING HOSPITALS

In the Spring of 1971 the Government changed the administrative authority dealing with hospitals and gave this responsibility to a newly formed Alberta Hospital Services Commission chaired by Dr. Jack Bradley. It was this commission with which we dealt with respect to interns and residents, their numbers and their stipends.

The practicality of having GFT positions in the teaching hospitals other than the University had only been tested at the Royal Alexandra Hospital with the appointment of Dr. J.A.L. Gilbert who established the teaching unit there in 1967. Despite the concern of some that we might be spreading our limited resources too thinly by considering additional appointments, the Long Range Planning (Advisory) Committee agreed to recommend after listening to

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* Limit was increased to $17,500 March 1971.

presentations in March 1971 from Dr. J.V. Williams of the Misericordia Hospital and from Dr. Gilbert, that the next GFT position be allotted to the Royal Alexandra Hospital.

If such an appointment was to fit rationally into the long-term plans of the divisions of the Department and if it was to reflect departmental priorities, we had to indicate from which one or two subspecialities such a person must come. The clinical teaching unit at the Royal Alexandra had been functioning well for some four years but the effect of the increased teaching load created by inexperienced student interns, the product of the new curriculum, had worried Dr. Gilbert and the six internists teaching on the C.T.U.

Negotiations began with the Royal Alexandra Hospital through the superintendent, Russell Nye, and Dr. Harvey Whiting, Chief of Medicine. Our proposal was that we seek a hematologist and Mr. Nye quickly obtained support of the Board which generously agreed to provide a secretary and office. We had asked also for assurance from Dr. Whiting that his Department would be supportive of a GFT hematologist.

It was with a mixture of disappointment and annoyance that I heard from Dr. Gilbert that the staff of the Department of Medicine had refused to support the proposal. My response was to emphasize that the Department had only one new position available for the current academic year and to state rather bluntly that the offer must now be withdrawn.

This resulted in a request from the Medical Advisory Board (RAH) to meet with them. My response to the rejection by their staff must have in part reflected my frustration at trying to accomplish more than was possible with limited resources. The Royal Alexandra's response was direct and to the point. At a meeting attended by Alderman Leger among other, I was informed

that the Departmental members would be persuaded (or told) to reverse their stand. I explained that there had been a single position available, that it could not be risked by assignment to a Department which was not enthusiastic and which would be even less supportive if over-ruled in their original decision. The meeting was not particularly enjoyable but I saw no advantage to reversing my position.

In November 1971, Dr. Whiting wrote me to say that the Department had passed a motion in which they accepted in principle a proposal for a second full-time person in the Department, "the individual and the sub-speciality to be mutually agreeable to the University and the Department of Medicine (RAH)". I replied "It is my hope that the Department of Medicine will eventually be able to support more full-time people at both the Royal Alexandra Hospital and the other teaching hospitals."

The Chairman dealt with two persons in the Department of Medicine (RAH) -- the Chief of Staff and the Head of the Clinical Teaching Unit. The staff at the Royal Alexandra Hospital was jealous of its independence and elected its own Chief of Staff in the Department of Medicine. It was easy to understand their antipathy to the recommendation of accreditation teams that the full-time University appointee be Chief of Medicine. On the other hand, the University appointee naturally imagined that he would be better able to influence the development of teaching and research programs if he had the recognizable authority of the Chief of Service and was integrated into the administrative functions of the hospital. Fifteen years later the positions of each side remain largely unchanged.

UNDERGRADUATE EDUCATION

THE SHAKEDOWN CONTINUES

As the students entered each new or modified year of the new curriculum the Department was told about the perceived problems and deficiences and the student body requested more representation on faculty committees.

We thought that on-going evaluation of students on the ward was an enlightened change from formal examinations, but they missed the security of a "final exam" and asked that it be instituted at the end of the clinical rotation. This was done.

In the hope that problems and concerns of individual students could be dealt with promptly, the faculty advisor system was instituted in 1970. Four or five students were assigned to a single member of staff who agreed to act in this capacity. The approach of staff members varied from a rather cursory attempt to arrange an interview to a genuine expression of friendship through an invitation to the home of the advisor. Like many other good ideas, and for the usual unexplained reasons, this plan never really succeeded and eventually melted into obscurity.

The status of the new student intern on the ward was not really understood by either the student or by the nurses and doctors. By the beginning of 1971, the Dean saw need to clarify this matter and Dr. Cameron issued a "Statement of Policy Re: Student Interns." This dealt with the way in which student interns should be addressed (the title "doctor" was considered inappropriate), and a description of their ward duties. Our Department expressed concern about the students' interpretation of the statement that "Ward duties of

all kinds will be assigned to the student intern only in so far as in the opinion of the faculty they make some contribution to his education." We observed that some students reduced their involvement to self-selected activity rather than becoming involved in the day to day care of the patient. It took time for both students and staff to learn and understand the new system.

In June 1971, I received the final report from the Ad Hoc Committee for Evaluation of Department of Medicine Undergraduate Teaching Committments. This Committee, chaired by Dr. George Goldsand and consisting of Drs. Gilbert, Silverberg and Sherbaniuk had met weekly for six months, concerning itself largely with instruction in Phase III. They made a number of observations and seven recommendations. They designated Phase III as the most important time for teaching and recommended that Phase II be restricted to teaching mechanisms. The need for training in history taking and physical examination was recognized and a four week course prior to Phase III was suggested.

They criticized the plan which had restricted teaching of student interns in the University Hospital to the General Medical wards and asked that subspecialists have an opportunity to instruct in their areas of expertise. With respect to the student on the ward, they emphasized his need to study each patient's problem in depth and warned against assigning an excessive number of patients to him.

Because student interns did not have experience comparable to the traditional intern of the past they emphasized the need for constant supervision which, they wrote, could only be provided by an organized pyramidal structure of house staff.

In order to implement their recommendations they proposed the establishment of a standing departmental committee (with student and resident represen-

tatives) which would have responsibility for all aspects of Phase III teaching.

The recommendations of the Committee met with no serious opposition. There were, however, changes flowing from these recommendations which could not be brought about quickly. As the Committee recognized, the housestaff constituted an important link in the chain of teachers and were responsible for the immediate supervision of student interns. In 1970-71 the Department was faced with a reduction in positions for house staff. Inadequate numbers had led in turn to unsatisfactory conditions for graduate training and coupled with a more militant stance resulted in a crisis in May-June 1971 to be described later.

The recommendation that larger numbers of students be taught at the University Hospital and that subspecialists take part in this had been coupled with the suggestion that the ward system revert back to mixed general wards with representatives of subspecialities on each one. This posed considerable difficulty because of the concentration of nursing expertise in the wards which then generally had medical staff from only two subspecialities and their appropriate patients. Within the limited number of subspecialities it was impossible to provide an expanded number of teaching wards each with a representative of every subspecialty.

The Committee recognized and described several significant problems and their report was the basis for a number of changes which were introduced over the next several years.

COMPUTER-ASSISTED LEARNING

The new curriculum introduced a "systems" program for second year in the

disciplines of Cardiology, Endocrinology and Metabolism, Gastroenterology, Hematology, Muscle Bone and Joint Disease, Pulmonary Disease, Renal Disease and a "Supplementary System" consisting of matters not otherwise dealt with.

The program comprised eight 4-week courses in each of the disciplines. As described elsewhere, the advantage to the students of being taught in groups of fourteen (later increased to sixteen after a reduction from eight to seven programs) was counterbalanced by the difficulty faced by the divisions in maintaining an enthusiastic level of instruction when repeating the same material seven times in each academic year. In addition, the instruction time had increased from 50 to 560 hours per year!

Dr. Dick Rossall had written an excellent (and popular) manual in Cardiology which had been used by the students for several years. He now initiated the first program in computer assisted learning in our faculty, a contribution which earned widespread recognition and interest of medical educators both in Canada and other parts of the medical world.

The programs for computer assisted learning in Cardiology were developed for use on the IBM 1500 System, used at that time in the Division of Educational Research Services in the Faculty of Education (under the direction of Professor Steve Hunka). With the help and advice of Professor Hunka and with programming development by Wayne Osbaldeston, Dr. Rossall produced a total of sixteen programs which dealt with heart sounds and murmurs, basic electrocardiography, rheumatic valvular lesions and congenital heart disease.

The incorporation of both audio and visual material into a program of text with which the student could interact by means of the light pen made this a deservedly popular and successful teaching program.

The success of Dr. Rossall's pioneer work led to the development of other programs of computer assisted instruction in the Faculty (Anatomy, Pharmacology). Through the resulting economy of instructors' time it also contributed to the solution of some of the problems inherent in the introduction of the new curriculum.

Since 1970 this program has been expanded and has been transferred to new and more versatile hardware to become part of the faculty system of computer assisted instruction.

This contribution of Dick Rossall continues to be used with enthusiasm by undergraduate students, post-graduate students and even practitioners seeking a "refresher" in cardiology.

STUDENT RESPONSE

The Executive Committee of the Faculty of Medicine in the Spring of 1971 agreed to motions giving student representation on the Curriculum and the Admissions Committees equal in number to the elected faculty members. The original intent had been to include the Student Evaluation Committee but this ran into opposition from some faculty members and finally failed in its intent when it was found that most, if not all the members on that committee were appointed ex-officio. Nevertheless the Dean was able to announce that the proposed increase in student representatives on Medical Faculty Council had been approved by GFC (April 1971).

These were days in which students resented "elitism". One manifestation was the decision of some of our best students to disband Alpha Omega Alpha,* an honour medical society which had been founded on campus in 1958. Another way of expressing their distaste for grading their academic accomplishments was to request a "pass-fail" marking system. Motions to bring this about were debated, referred and eventually resulted in a Committee being struck to consider grading, marking etc. The enthusiasm of some for a pass-fail system never seemed to be reflected in a significantly large number of the students and it eventually disappeared from the agenda.

GRADUATE TRAINING PROGRAM

THE HOUSE STAFF

The House Staff Newsletter of May 13, 1971 called for an Emergency Meeting of the Medical Graduate Society on May 18. In a red diagonal line across the front of the page was printed "STRIKE?"

For the year beginning July 1971, we had contracted thirteen first year straight interns and residents, thirteen for second year, four third year and three fourth year, for a total of thirty-three. In the House Staff Newsletter of April 12, 1971, the writers stated that housestaff in Alberta received the lowest pay in North America. Comparative figures were given for Alberta ($5616-$8100) and British Columbia ($6360-$9960). Dr. Roger Amy complained in

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*The Society was revived in the more receptive milieu of 1982.

an editorial of the lack of support for the housestaff from colleagues, instructors and the Alberta College of Physicians and Surgeons. Their association hired a lawyer to assist in negotiations. They described themselves as "very unhappy and demoralized". But Dr. Malcolm Young, President of M.G.S. concluded by saying "The press has not and will not be involved" and "A strike is, in all cases an outmoded and uncivilized form of protest". He stated that they had received very strong support from the University Hospital Board, the Faculty of Medicine and many members of the Medical Staff. Nevertheless, the Housestaff were frustrated by what they considered delaying tactics of Government and felt they were pawns in political games.

Changes were occurring in graduate training. In the fall of 1970 the first Fellowship examination (Cardiology) in a medical subspecialty (other than Dermatology and Neurology) was introduced by the Royal College. This established a pattern of a multiple choice papers for both clinical medicine and basic science, an essay type paper in the sub-specialty and an oral examination. This lead was quickly followed by other subspecialities and the training program in the University Hospital became oriented to those subspecialities which had accredited programs. This reduced the number of trainees in General Medicine,* particularly in senior years, and in turn made it more difficult to second senior residents to the other teaching hospitals where, even to this time (15 years later) there are no fully accredited subspeciality programs.

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*At the University Hospital 23 of 33 residents were in subspecialities.

The emergence of the Faculty of Medicine in Calgary on to the graduate training scene raised questions about supply and demand for specialists. The Government's expressed policy was to recognize the requirements of Alberta but to overlook the national character of medical manpower and the mobility of the profession.

Dr. Rossall, as Director of Graduate Training for the Faculty, chaired a Committee on Medical Manpower which estimated the number of internists and other specialists needed to meet the attrition of the profession and the increasing provincial population. The results were presented to the staff at the University Hospital, at a meeting of the Alberta Medical Association and to the Edmonton Academy of Medicine. This careful study contained the best information available for planning graduate training programs but each Director of a program (and each of the two University centres) was naturally determined to expand or at least maintain the enrolment in his program. The Alberta Hospital Services Commission adopted the attitude that their responsibility was limited to determining the dollars to be spent and did not seek advice about how they should be spent in the support of graduate trainees. For these or other reasons, there was little rational relationship between the projected requirements for specialists and the training programs. This conclusion is reached despite the appointment by the commission of an Advisory Committee on Terms and Conditions of Employment of Residents and Interns. This committee was composed of Deans MacKenzie and Cochrane, Dr. B. Snell, President of the University Hospital, a representative from the Commission and representatives from two of the Affiliated Teaching Hospitals. The mechanism for appointment of residents called for proposals from Directors of graduate training programs to be made to the Advisory Committee after such proposals had been approved by the appropriate Chairman and Dean.

In a memo to Chairmen, dated July 21, 1971, Dr. John Read, Vice-President (Medical) wrote that the Executive Council of Government had asked the Commission (A.H.S.C.) to:

1. Recommend the number and type of residents.
2. Give specific approval for the appointments of house staff.
3. Determine their distribution within the hospitals in the Province.
4. Set their salaries.

As seen by the Directors and the graduate trainees, the major function of the Commission with respect to residents appeared to be that of treasurer on behalf of government. Little evidence suggests that future manpower requirements played an important role in either the recommendation to them of their Advisory Committee or their subsequent decisions.

For 1971-72 the Commission agreed to fund 154 1/2 positions which, with additional outside sources resulted in a total of 177 positions being made available for the Province.

The Faculty had a continuing program for Teaching Fellows, largely filled by those residents who had completed their requirements for, but had not yet written their Fellowship examinations. Fellows had provided a helpful cadre of junior teachers, fresh from their training programs and usually enthusiastic clinical teachers of students and interns.

By 1971 the stipend for Fellows had not kept up with that paid fourth year residents and the positions became increasingly less attractive. We were left with five vacancies which reduced our manpower for ward teaching.

Money also played a part in inducing increasing numbers of residents to "moonlight", usually by working in Emergency departments (which the hospitals were loathe to discourage) or taking admission histories in hospitals such as

the W.W. Cross where residents were not generally available. The Divisional Directors discussed this matter at the request of the Departmental Director of Graduate Training, and while not forbidding this practice, drew up the following rules:

1. The Department must be informed by any resident who is accepting outside employment.
2. It must not compromise his regular duties.
3. Such activities would be taken into consideration at the time of his evaluation every three months.
4. New residents are to be discouraged by their program directors from moonlighting.

The acceptance of these rules by all Divisional Directors was useful in defining the boundaries and resolving a tiresome and somewhat troublesome problem.

RESEARCH

Research activity in the Department showed a steady increase as mirrored by the growth of research funds from $417,284 (1969) to $683,527 (1970) and $802,705 (1971). The success of the transplant program under the direction of Dr. Dossetor contributed appreciably to this increase. His division (Nephrology) had also interested other groups in the four western Canadian centres in a multicentre evaluation of immunosuppression of glomerulonephritis.

Dr. Pierre Band with the support of Dr. Adam Little, Director of Hematology, was actively involved as a member of the Eastern Oncology Group in chemotherapy trials. Dr. Weinstein made rapid progress in establishing his laboratory to study intestinal cellular kinetics and successfully attracted funds from the Medical Research Council. Dr. Nick Bruchovsky was responsible for a

well-established and nationally funded program in cellular biochemistry as applied to neoplasia. Dr. Lynne-Davies, Dr. Garner King, Dr. Alec Herbert and Dr. Brian Sproule in the Division of Pulmonary Diseases, Dr. Lee, Dr. Rossall and Dr. Friesen in Cardiology, Dr. Aaron in Allergy, Dr. McPherson in Oncology, Dr. Goldsand in Infectious Diseases, Dr.McLean, Dr. Nihei and Dr. Monckton in Neurology, Dr. Percy in Rheumatology, Dr. Watanabe and Dr. Crockford in Endocrinology and Dr. Gilbert in General Medicine all contributed to the published papers and the numerous scientific addresses (113 in 1970; 143 in 1971).

At the meeting of the Executive of Faculty Council in March 1971, a plan initiated by Dr. Dossetor for an Interdisciplinary Ph.D. program embracing the Departments of Bacteriology, Immunology, Medicine, Pathology and Pediatrics, received support and the sponsors were encouraged to progress up the line of committees to seek ultimate sanction from the Coordinating Council of the Universities.

The competition for funds from national granting bodies was becoming increasingly difficult and I thought we should do our best to produce well-written, persuasive grant applications.

In the Spring of 1971 two committees were appointed to help applicants with their grants. One was the Scientific Committee consisting of Dr. John Dossetor, Dr. Pat Lynne-Davis and Dr. Alex McPherson whose task it was to review grant applications. The second consisted of Dr. Nick Bruchovsky, Dr. John Dossetor and Dr. Sproule who were available for advice concerning scientific merit.

The Clinical Sciences Building which we occupied in the Spring of 1969 proved to be a welcome and essential space within which research activities

could be developed and expanded. Prior to this what limited research was undertaken was done in space generously provided by the University Hospital. Despite what appeared to be an abundance of space, the Department soon filled the four floors (6,7,8,9) allotted to it.

The uses were mixed, reflecting our responsibilities. Because little other suitable space existed for seeing an increased number of referred patients, some space was given over to examination rooms and a minimal amount to waiting areas. Some diagnostic laboratories were established owing to a lack of space in the Hospital, and also because they usually combined research with service; for example, Cardiology, ECG Laboratory, Pulmonary Function, Endocrine, Gastroenterology, Rheumatology and Infectious Diseases Laboratories. Lecture rooms and bench type research laboratories occupied almost all the remaining space, quickly leaving little room for expansion.

Nevertheless we were usually able to promise new appointees appropriate space for their research, an essential ingredient of a recruiting package for a promising applicant.

ADMINISTRATION

ADMINISTRATIVE OFFICER

When I succeeded to the Chairmanship in 1969, I was relieved and grateful that Gordon Kerr was willing to stay on as Administrative Officer to see me through the first two years. He had been persuaded by Dr.Wilson to leave Ottawa and join the Department of Medicine as the first Administrative Officer to be appointed in the Faculty. In a very short time this retired Air Vice Marshall had gained the respect and affection of every member of our Department by his sincere interest in their welfare, his quiet efficient development

of a position which he had to create and his unfailing gentlemanly response to complaints and demands, however unreasonable. Both he and his wife acted as parents to new members of staff, many of whom must remember being greeted by the Kerrs on their arrival in Edmonton.* Gordon Kerr did much to ease me into the responsibilities of the Chairmanship and continued to support me and serve the Department for another two years. Near the end of the promised two years he reminded me that he and his wife Ethel planned to return to Ottawa, to spend the summer there and the winter in Florida.

I chaired a Search and Selection committee consisting of a full-time and a part-time member of the Department and Al Maiani, the Faculty Administrative Officer. We short-listed a surprising 43 applicants to 6. They were excellent applicants with a wide variety of education, training and experience. The Selection Committee agreed that an essential quality must be the person's ability to deal effectively with people, and in a Department such as ours this ranged from Technicians, Secretaries, University administration, Hospital administration to our own staff of generally reasonable but sometimes opinionated and even arrogant physicians!

The Royal Canadian Navy had recognized the quality of leadership in Hal Fearon, recently retired Commander and formerly Executive Officer on the Bonaventure. He was both a fixed wing and helicopter pilot. Hal accepted our offer and took a brief introductory course from Gordon. He then provided me

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*One of our Departmental members fondly recalls Gordon and his wife arriving at the door of their bare new house into which they had just moved, with a pot roast and a bottle of rye, a typical act of kindness repeated many times by this warm-hearted couple.

with loyal and unfailing support through the next two years of troubled waters. His capability was recognized by the Dean who persuaded Hal to leave the Department in 1974 for the Dean's office where he succeeded Al Maiani who left to take up an administrative position in a Calgary hospital.

BUDGET

In the annual report of the Department for 1970-71 the year was described as "as period of consolidation resulting ----- from economics imposed by budget restriction". The stop hiring order of September 28, 1970 was followed in May 1971 by a meeting of President Wyman with all Deans, Directors and Chairman at which the difficult financial situation was discussed. Brian McDonald, the Assistant to the President and later Associate Vice-President (Adacemic Administration) startled a number of those attending the meeting by presenting a study which he had carried out to determine what saving could be reached by eliminating the Faculties of Law and Physical Education. Fortunately for those two faculties, his conclusion was that no savings could be expected. He went on to show that if the costly faculties of Medicine, Dentistry, Agriculture and Library Science were discontinued the University could operate at a profit! Fortunately for us this was an impractical solution, unacceptable politically. It remained however for Dr. Wyman, his administration and the Board to "make major decisions", particularly because the Government grant was changed to fixed dollars and would not increase with any increase in student numbers.

The budget of the Department consisted of salaries (academic and non-academic) and non-salary operating costs. Research funds were the responsibility of the grant recipient.

The Chairman had no control over salary items. Salaries for academic staff were tied to the number of authorized positions and the salary schedules for rank. Increments were determined by the decisions of Faculty Salary and Promotions Committee subject to overall limits applied to the Faculty (110% was the permitted level for increments).

Non-academic salaries were also tied to salary and wage scales. Recommendations originated annually with the immediate supervisor for increments and there was little room for dispute.

The budget base for the Faculty was increased by the budget adjustment allowance and an inflation allowance, all done by central administration.

As the year end approached, deficencies in one budget item could be made up by an authorized transfer from a comparable item. In practice the Chairman had no discretionary funds except those accruing through excess earnings of clinical staff. These were never guaranteed, but fortunately they continued to accumulate while I was Chairman and constituted an exceptionally useful resource.

THE BUILDING PROGRAM

Phase II of the Basic Medical Sciences Building was approved in June 1971. Because many other plans depended on the completion of this building, we received this information with relief. Less encouraging was the instruction from the Alberta Health Services Commission that a "hold" had been placed on the Centennial Hospital on June 25, 1971. The cost of the project had by then exceeded the approved limit, even allowing for an inflation of some 28% in costs from 1968-71. The Hospital administration was told that the projected cost of 51.9 million must be reduced to 42 million. The task of reducing

the cost was given to a committee corsisting of Dr. Snell, President of the Hospital, Dr. Cameron, Acting Dean of Medicine, Dr. Read, Vice-President (Medical), Dr. MacBeth, Chairman of Surgery, myself as Chairman of Medicine and Dr. C.M. Couves of Surgery. Further events of the summer of 1971 will be described later.

CHAPTER IV

THE WORLD AROUND 1971-1972

The recession with the twin accompaniments of inflation and unemployment became more firmly established. Prime Minister Trudeau's Finance Minister Benson announced government spending and tax cuts in a futile attempt to improve industrial activity and increase employment. Terrorists and hijackers became a part of international life. President Nixon announced that he would visit China and Louis Armstrong died.

Apollo 15 was launched in July and Scott and Irwin spent the week-end cruising the moon's surface. A growing number of nations launched their own military satellites, confirming the change which this new technology had made in world communication.

Charges were dropped against twenty defendents in the Kent State University trials for lack of evidence. Only isolated instances of student unrest continued to occur in the United States, although student protests became more widespread throughout the rest of the world.

Nikita Krushchev, successor to Stalin, died in September 1971 and Edgar Hoover of FBI fame died in May 1972. The medical world lost Nobel Laureate Physiologist Bernard Houssay and Lord Boyd-Orr, Scottish physician and nutritionist and the former first Director of the United Nations Food and Agriculture Organization. Edward Kendall, biochemist at the Mayo Clinic who isolated thyroxin and six hormones of the adrenal cortex and who received the Nobel prize in Medicine jointly with Phillip Hench and T. Reichstein in 1950, died while a visiting professor at Princeton, May 1972.

In Canada, we commemorated the fiftieth anniversary of the isolation of insulin by honouring Dr. Charles Best, the only living member of the original four players in this medical drama.

Dr. MacKenzie left in the summer of 1971 for a years sabbatical during which he visited medical centres around the world, demonstrating once more his effectiveness as an ambassador of this Faculty-perhaps more correctly of Canadian medicine. For twelve months Dr. D.F. Cameron, long-time Associate Dean, was Acting Dean. It was not a happy time at which to take on this responsibility. At the first meeting of the Executive Committee of Faculty Council he warned that no new ongoing commitments for academic staff could be entertained. In December he told the Executive Committee that there would be a budget reduction in 1972-73.

THE BUILDING PROGRAM

In July 1971, Doctors Cameron, Snell, Read, MacBeth, Couves and I met daily for most of one week before we completed the depressing task of removing enough of the Centennial Hospital from the plans to reduce the cost to the limit permitted by the Government. That done, and despite our feeling that we had removed some essential space and functions, we waited with relief for the start of construction in August.

Premier Strom was taking the Social Credit Party into the first election since the retirement of Premier Manning in 1969. During the preceding two years the opposition had been effectively led by Peter Lougheed and the public had become restless and tired of a party which had been in power since 1935, a record thirty-six years.

Nevertheless, we were as astonished as were most Albertans to learn on August 30, 1971, that the Strom government had been defeated by the Conservatives.

The ground between the Interns Residence and the Clinical Sciences Building had been fenced off and the heavy equipment was about to start the excavation. Dr. Snell sought advice from the Minister's office and was told that the project was to be put on hold. This was confirmed on September 9, 1971. At that time none of us imagined that the "hold" would last five full years until the public announcement of approval for a "World Class" Medical Centre in October 1976.

In the intervening years our staff became increasingly frustrated by the inability to improve or expand facilities to meet new needs and to introduce new programs. There was an understandable reluctance on the part of government to authorize upgrading or even repair of buildings which might soon be demolished. Requests for even essential renovations were often rejected and departments and divisions tried to make do in obsolete quarters.

In 1971-72 the Department of Medicine became aware of the substandard nature of the facilities in the Mewburn Pavilion,* a building which some said was constructed in 1944 to plans and standards of the Department of Veterans Affairs resurrected from before the First World War. However, the "Mewburn" provided essential beds for our Department; most of the male patients in General Medicine and patients of Nephrology and other Divisions continued to be housed in these quarters.

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*The Colonel Mewburn Pavilion, named after the first Professor of Surgery, was formally opened in February 1945.

In November 1971, Dr. Snell in speaking to the Coordinating Committee, summarized the effect which the hold (placed by the Alberta Health Services Commission) was having on the project. In addition to interrupting the plans for obtaining a matching grant of 7.6 million dollars from the Federal Government, the delay was costing $7,800 per day and re-planning was currently estimated to be $2,900 per day. At this time Mr. R. Clarke was Project Director and Poole Construction was the construction management firm, acting as an agent of the Hospital Board.

Dr. Cameron described the situation in which the Faculty found itself, pointing out that the current educational programs of the Faculty were using all the available facilities in the city and that the earliest possible completion of the planned facility was needed for our undergraduate and graduate programs.

The new Government of Premier Lougheed replaced the University of Alberta Health Sciences Centre Planning and Development Committee by a Provincial Health Sciences Authority, a University of Alberta Health Sciences Planning and Development Committee and a University of Alberta Health Sciences Liaison Committee (University, University Hospital, W.W. Cross and Provincial Laboratory).

By June 1972 we were resigned to what seemed to be an endless series of delays. The fence erected the previous summer was removed and the area was black topped for a parking lot.

THE UNIVERSITY HOSPITAL

The Hospital annual report contained a sentence from a joint statement of Gordon Wynn, Chairman of the Board and Dr. Snell, President of the Hospital which appropriately described 1971 as "a difficult and significant year!"

The Hospital took over the administration of the Aberhart Hospital which had facilities much in excess of current requirements for the treatment of tuberculosis. The Division of Respiratory Diseases, joined by Infectious Diseases were asked to accept clinical responsibilities, and plans were initated to transfer patients with respiratory poliomyelitis and those with chronic lung disease from the University Hospital to the Aberhart. Some of the full-time clinical staff of the Aberhart retired or left but others stayed on, employed by the University Hospital.

Dr. Sproule and I had proposed that the monies formerly available for hiring professional staff in the Aberhart be transferred to the Department of Medicine which would then accept the responsibility for servicing that area. This would have made it possible to rationalize staffing with respect to the triple function of service, teaching and research and, we thought, would have made attractive University-type positions available for new staff. The administration of the Hospital considered these suggestions neither feasible nor in the interest of the Hospital and physicians became part of what some of our members referred to as "Dr. Read's Department of Medicine."

Within the University Hospital essential improvements were accomplished despite the tight budget: the coronary observation unit was increased from four to six beds; the inadequate space for the intensive care unit on Station 67 was replaced by refurbishing a large ward on Station 42; Dr. Ulan became Director of the Regional Dialysis Program, both home and in-hospital.

Gastroenterology reported that over 2000 mucosal biopsies had been reviewed jointly with the Department of Pathology; colonoscopy was introduced into their list of invasive procedures and a G.I. motility laboratory was established.

General Medicine, to which six part-time physicians were admitting, had the responsibility for taking care of undesignated patients coming in through the Emergency. This included those with over-doses and alcoholism, a category which no service was keen on admitting. To increase their bed allotment to more realistic figures (they had 62 beds, shared with Infectious Diseases) we proposed they take over MP6 and MP8 to provide them with an additional 50 beds. This was later accomplished.

Although the Hospital listed 1253 beds and 117 bassinettes, our Department had continuing difficulty in admitting patients, a problem which was exacerbated by a steady increase in admissions through the Emergency.

The burgeoning activity of the Cardiovascular surgeons had increased the demands on the cardiologists who were called on for the additional pre-operative and post-operative investigations and care. Cardiac catheterizations and selective angiograms increased respectively from 551 and 882 in 1970 to 682 and 1015 in the calendar year 1971.

I argued on behalf of the Department that beds in the University Hospital were not appropriately distributed among Departments. Surgical subspecialties had developed much earlier than those in Medicine and were clearly enough defined to be allotted separate clinical space.

The Department of Medicine was still, at that time, thought of as the counterpart of General Surgery. This made imbalances between our Department and the whole Department of Surgery (including its subspecialities) less apparent. We calculated that 22% of the University Hospital beds were assigned to Medicine, whereas in the several teaching hospitals in Toronto the average proportion of hospital beds controlled by Medicine was 27.7%. If our Department had the same entitlement we would have had 68 additional beds which would

have made the tasks of Ward Chiefs, Divisional Directors and the Chairman a great deal less onerous. Unfortunately, these would have had to come from other clinical departments and it was understandable that I found no champions of our cause at the meetings of the Medical Staff Advisory Committee!

In extracting comparative figures from reports of the Association of Canadian Medical Colleges we also recognized a discrepancy between us and Toronto with respect to positions for housestaff. In the graduate training programs of Toronto there were approximately fifteen positions available per graduating student; in Edmonton there were four. Although this smaller number could theoretically provide four years of training for each graduate, in practice we were continually running into difficulty because of holiday time (1 month per year), non-clinical periods of the training and maldistribution of interests on the part of these young people. As a result we faced difficulties in satisfying service needs while honouring the requirement of good training programs. The solution to this remained for Dr. Molnar to find through a gradual increase in numbers and by strengthening the quality of the programs.

It became apparent that the Hospital needed a clearer description of the function of clinics held in the outpatient area. Dr. Mario Tedeschini, President of the Medical Staff described in a letter to the staff a proposal to establish a Health Sciences Clinics Committee which would comprise a representative from Hospital Administration, an appointee of the Dean, the Chairman of Ambulatory Care, an appointee from the Medical Staff Advisory Committee and four representatives from the medical staff.

This Committee was charged with the responsibility of establishing policy and approving/disapproving the establishment of clinics.

Their authority was to include the Clinical Sciences Building. The purposes for which clinics could be established were the following:

1. To provide a professional service not otherwise available
2. To provide services to groups not likely to receive care elsewhere.
3. To permit clinical research/training

In recognition of the need for patients in teaching programs provision was made for physicians to see their private patients in ambulatory care and they were permitted to charge as they would have in their offices. For other patients an overhead fee was extracted by the Hospital after which 50% went to the Department and 20% to the Medical Staff Academic Fund.

The Department of Medicine remained a major player in this activitiy over the next decade, some representative clinics being, Neurology, General Medicine, Dermatology, Muscular Dystrophy, Parkinsonism, Multiple Sclerosis and Epilepsy, Nephrology and Transplantation, Pulmonary, Rheumatology, Endocrinology and Cardiology.

The Government was gradually working out applications of policy written in the Health Care Acts of Provincial and Federal origin. In September 1971 we were informed that interpretation of regulations concerning diagnostic tests carried out in hospital on in-patient or outpatients and when hospital equipment was used, was that the professional interpretive fee was included in the hospital benefit. This immediately affected the interpretive fees for electrocardiograms and electro-encephalograms. Dr. Snell was less certain about cardiac catheterization and pulmonary function tests. The former continued to be accepted as a professional charge by the Health Care Insurance Commission; the latter was treated in much the same way as were ECG interpretations.

The decision concerning ECG and EEG interpretations led to early negotiations between members of our Department and hospital authorities both here and in Calgary. To the hospitals this meant an added cost for which they would probably make no offsetting recovery from government. To the readers it meant arguing that the fee schedule applied to this service as much as to any other. At the University Hospital members of the Division of Cardiology and others had for some years contributed the larger proportion of these fees to the ECG Trust Fund which was used to further academic activities. We were able to assure the Hospital that we would agree to a reasonable maximum number of tracings per year for which charges would be made and in return the Hospital continued to pay for each interpretation. This arrangment has worked to our mutual satisfaction and we avoided the sliding scale of diminishing payment as the numbers increase, an undesirable and in our opinion unprofessional arrangement reached in some other centres.

GRADUATE TRAINING PROGRAM

The emergence of subspecialty programs, the development of examinations and recognition by the Royal College led to approval of a training program in Cardiology in 1970 and to the acceptance of the first trainee in Gastroenterology in 1972.

In the Fall of 1971 at a meeting of the Chairmen from the Departments of Medicine from the Canadian Medical Schools, the Chairmen endorsed a recommendation that a meeting be held of members of the Royal College Committee on Internal Medicine, Chairmen of Medicine and Directors of various programs from across the nation. Several matters deserved discussion and among the most pressing were: the descriptions of "core training"; medical manpower require-

ments and its relationship to the number of trainees; the place of the straight intern; and finally, the recently introduced in-training evaluation of trainees. Ramsay Gunton (Western Ontario) who was on the Royal College Committee in Internal Medicine expressed the fear that the development of sub-specialty recognition had tended to reduce the importance of General Medicine and he did not believe this was a desirable trend.

The proposed meeting was held in the Spring of 1972 at Queen's University and Drs. Sprague, Goldsand and I represented our Department. Meetings such as this were effective in dealing with such matters as in-training evaluation but much less successful in considering numbers of trainees, number of residents and medical manpower, simply because there was a good deal of difference between Alberta and other Provinces (such as Ontario) in the way positions for residents were granted, controlled, allocated and paid for, and the necessary data on which to make decisions were either too unreliable or were missing.

A happy outcome, not of this meeting but of the general membership of the College, was the decision in 1971 to discontinue the separate examination for certification and have a single examination leading to Fellowship.

In September 1971 our graduate trainees numbered twenty three at the University Hospital, six at the Royal Alexandra Hospital, three at the Misericordia Hospital and two at the Edmonton General Hospital. By October 27, 1971, Dr. Grisdale, then Director of Post-graduate Medical Education of the Faculty, was able to tell me that Dr. Bradley had agreed to pay for 143 graduate trainees in 1972-73 (total in all programs of the Faculty), a <u>decrease</u> of 11.5 positions from the number supported in 1971-72. To indicate priorities of the Government he also agreed to add fifteen positions for the second year of the Family Practice program and seventy-two positions for straight interns and first year family practice.

At a meeting of the Department of Medicine on October 22, 1971 which he attended Dr. Snell explained that the reduction in house staff positions was dictated by the requirement to staff the new hospital in Calgary (the Foothills). In the Department of Medicine we were assured of 29 1/2 positions to which four or five straight interns could be added. Between the Fall and April 1972 we made no progress in increasing our allotment although four positions in Neurology were considered to be in addition to our total of thirty-four, a far cry from the fifty-four which we had attempted to justify from estimates of the Provincial needs in October 1971. Effective numbers had been further reduced when those seconded to the Royal Alexandra Hospital ceased to be paid from that hospital's budget.

Dr. John Read was most helpful in offering us the use of such intern positions as were available to him. Those in effect could be converted into first year residencies. This arrangement continued for some time and was later appreciated and made use of by Dr. Anholt when he became Assistant Dean, Postgraduate Medical Education.

As explained earlier, the system governing housestaff had changed rather quickly and significantly. To be approved by the Royal College, programs were required to be controlled through the University (Faculty of Medicine). No longer could large teaching hospitals run their own programs. If they did offer unapproved programs, they would not attract any better class graduate trainees. The financing of the training program was now authorized by the Alberta Health Care Commission. Dr. Bradley, Chairman, wrote in a letter of November 29, 1971 that he could deal only with the two Universities and that in each case the money would go to a "central" authority. In practice this proved to be two hospitals, the University (Edmonton) and Foothills (Calgary).

In May 1972, $2,796,700 was budgeted by the Commission for housestaff. The salaries ranged from $7,900 for Resident I to $10,000 for Resident IV. The Housestaff Newsletters at the University Hospital provide a reflection of the concerns and frustrations of those in the graduate training programs at that time.

One hundred "beepers" were expected by December 1971 but the Department of Medicine had refused to find the monthly rent of $10 to provide a "beeper" for each medical resident in September - a minor budget problem but a major error in personnel relations. The residents were experiencing that sense of uncertainty in predicting what might be expected of them by examiners of the Royal College and asked for selected reading lists from each of the subspecialty services. I solicited these on their behalf but whether any significant use was made of them, I cannot say. Teaching rounds numbered more than twenty a week but the major difficulty residents experienced was in detaching themselves from their own service to attend rounds of another subspecialty. Several years later this difficulty was overcome in good part by scheduling most rounds for the noon hour.

Non-medical news and information sometimes appeared on the pages of the Housestaff Newsletter. In the November 23 issue (1971), Dr. Read advised the housestaff that the City Police knew that a considerable amount of marijuana had been brought to the city by a member of the housestaff and that some was being sold. They suggested that an anonymous phone call to them or Dr. Read to indicate where the drug would be left would interrupt their further investigation. This must have been an attractive alternative because we heard no more.

When he met with the Department of Medicine in October 1971, Dr. Snell made the prophetic comment that "the major worry is that medical schools may be graduating more students than there are resident positions available". Ten or so years later this became a matter for national concern and lively debate among the medical schools, the Intern Matching Service and the licensing authorties.

Medical students had already earned representation on most committees of the Faculty. In 1971 those trainees registered with Postgraduate Medical Education in the Faculty were invited to send four representatives to sit on Faculty Council. One of these was entitled to sit on the Executive of Faculty Council. Although the Faculty of Graduate Studies had never recognized our graduate trainees unless enrolled in a Masters or Doctorate program, it had seemed appropriate to us in the Faculty of Medicine that the representatives of the Housestaff contribute to committees of the Faculty.

UNDERGRADUATE EDUCATION

Academic Plan 9 of the University of Alberta developed by the Academic Development Committee visualized 24000 full-time students. The Faculty of Medicine was asked to specify the allocation of positions within the faculty and Dr. Cameron in 1970 designated 125 places to regular and an additional 10 places to special undergraduate students. The remaining positions were reserved for those in Masters and Doctorate programs.

At some date which was probably later in 1971 I responded to a request from Dr. MacKenzie for our Departments' comments on the effect of expanding student first year enrollment in the M.D. program to 150.

Our response began by asking whether manpower studies justified a need for more graduates and if so whether such an increase could be more economically planned for medical schools with classes smaller than those in Alberta.

We continued by enumerating our needs in order to take on additional teaching responsibilities and emphasized our deficiency in staff resulting from unfilled promises at the time the new curriculum was introduced. Referring to data from the educational issues of the Journal of the American Medical Association we argued that we currently had one quarter of the clinical teaching staff of the average American Medical School. In Phase II alone our Department members taught 312 hours a month.

We also saw significant difficulties in providing more clinical teaching in Phase III because of a scarcity of suitable teaching wards in the affiliated hospitals.

Our conclusion was that we would require a minimum of 20 additional full-time staff and 24 more part-time staff. Neither of these requests seemed exaggerated when we could point out that the Department of Medicine at the University of Colorado had 70 full-time teachers for a graduating class of 88 and at the University of Washington in Seattle, where the graduating class was 80 (some 30 less than Alberta) the Department of Medicine had access to 300 part-time internists for clinical teaching!

Whether or not other Departments responded in a similar vein I do not know. At any rate, there appeared to be no momentum behind the suggestion that we increase the number of our undergraduate students. A Committee on Medical School Enrolment recommended in November 1971 that any increase in students be deferred to at least 1973. In the light of subsequent events the decision was indeed correct.

The Department voiced their disquiet about the poor showing of our graduating students in the exams of the Medical Council of Canada. The class which wrote in the Spring of 1971 were the products of the old and the "junctional" curriculum but the staff at the Departmental meeting of April 28, 1972 were probably apprehensive of the effect of the new curriculum on future Council exam results, since they identified history taking and physical examination as "the single largest (sic) weakness in teaching of Medicine." They asked the Dean that this matter be given priority among the various changes required.

The concern of clinical teachers for their students' skills at the bedside has been a recurrent one and has resulted in periodic revision of the formal efforts to teach these skills. It seemed strange to me that it was only a minority of our teachers who insisted on a reasonable standard for students, undergraduate interns, or residents in their case presentations and fewer still who watched a student examine a patient or led the student into more skillful ways. Indeed, because bedside examination is a skill it is surely something we should expect students to become progressively more adept at as they complete their formal training, and this requires the teacher's continuing attention.

The students established the "Outstanding Teacher Award" in 1972, an honour which has been valued in the Faculty and which has been awarded to members of the Department of Medicine on 10 occasions in the subsequent thirteen years by Phase III students.

The interest of the students in a pass-fail grading system had not evaporated and in an effort to initiate it within the Faculty, they proposed a trial of this in Phase II for one year.

Instructors were still struggling with the fatiguing responsibility of teaching to a repetition of small groups throughout the year. The Divisional Heads agreed to seek a solution but no ready one came to light at their meeting in May.

The teaching staff at the Clincial Teaching Unit, Royal Alexandra Hospital, were disgruntled and a meeting was held with those instructors, Dr. Bill Black, Dr. Gilbert and me. To me it seemed that they had been inadequately prepared by those of us who knew what changes would be introduced by the new curriculum. Although there had been a temporary "overload" of the unit with undergraduate interns, only eight students were assigned as of June 1972 to the C.T.U. and half of those spent time on other wards. The clinical instructors at the R.A.H. were dissatisfied with the level of skills possessed by the students, not recognizing that teaching those very skills was one of their responsibilities under the new curriculum. They also worried that the student interns would displace the traditional first year interns which had long been an important ingredient in their teaching program.

In concluding our discussion, I could only offer to place the students elsewhere if they no longer wished to teach them. Subsequently Dr. Gilbert wrote that "the objection is more to the whole concept of Phase III which gives priority to the student intern" and that the six clinical instructors did not like teaching on the C.T.U. because there were no rotating interns. Despite this discontent Dr. Gilbert managed to retain his teaching staff, and the C.T.U. with its 45 beds continued to function under his effective direction. Some improvement took place after a system of rotating the teachers annually through the C.T.U. was developed. Those who were not teaching any particular year were kept on University staff with a small honorarium.

At the University Hospital the Medical Outpatient Department still existed although its original need to provide care for the indigent had disappeared with the introduction of compulsory medical care insurance. Attempts were made to attract patients who would be suitable for teaching clinics but this met with quite variable success. In 1972 Medical clinics were held each Tuesday and Friday. Dr. Neil MacDonald and Dr. Regina Donnelly, Dr. Nick Bruchovsky and Dr. John Dossetor were joined by two undergraduate interns as each pair of doctors took one of the two weekly sessions. The Department was indebted to these faithful members for maintaining a presence for us in the traditional sense of outpatient (ambulatory) medical care and teaching.

In order to provide some unification of teaching within the several Clinical Teaching Units we established a Committee on Phase III Medicine in July 1971. This committee comprised all Heads of C.T. Units and Dr. Goldsand as Chairman. It was heartening to learn from this group that by 1972 the students in their opinion, had shown "real improvement."

THE FACULTY

The freeze on recruiting new staff to hard-funded positions had virtually brought this to a stop. The Divisional Heads, nevertheless, continued to search out other ways of attracting promising prospective members of our Department.

In July 1971 Dr. A.S. (Tony) Russell joined the Division of Rheumatology as a Assistant Professor, supported by a fellowship of the Canadian Arthritis and Rheumatism Society. This voluntary health organization was already supporting Dr. John Percy and had been responsible for the early support and de-

velopment of clinical facilities initiated by Dr. E.G. Kidd, Dr. Ken Thomson and Dr. David Bell.

Dr. Russell was a Cambridge graduate in Medicine (1963) who pursued his graduate training in England at Guy's, the Royal Post Graduate School of Medicine and the Rheumatic Research Unit, Taplow. He has continued to the present time to contribute effectively in clinical practice, teaching, research and departmental administration. In March 1974, he agreed to serve as Co-ordinator of Research for the Department.

The Long Range Planning Committee recognized early in its deliberations that the choice of part-time staff would have to be carefully made if the Department was to grow in a balanced manner. In 1971-72 there was a need for another general internist, and a recent graduate of our training program, Dr. Regina Donnelly, was appointed. She stayed with us until she and her husband (an orthopedic surgeon) moved to Red Deer.

The increase in clinical demands on the cardiologists made it apparent that a part-time person, rather than another G.F.T. was essential to meet the expanding program in the treatment of coronary artery disease. Dr. Joe Dvorkin had a large clinical practice. Despite the demands of his practice he was a devoted and popular teacher and a pioneer contributor to the development of cardiology at the University Hospital. The Department agreed with his request to bring Dr. Carmen Brooks on staff as an eventual partner of Dr. Dvorkin's. Dr. Brooks was the first graduate trainee in the Division of Cardiology and succeeded in obtaining his Fellowship in that specialty in the Fall of 1972. He resigned from the staff in January 1976 to practice in Phoenix, Arizona.

In December 1971, a geographic full-time member of the Division of Cardiology since 1969, Dr. Glen Friesen wrote to Acting Dean Cameron, Dr. Rossall, Director of the Division of Cardiology and to me as Chairman of Medicine. In those letters Dr. Friesen expressed his dissatisfaction with facilities for clinical research, the care of the patients with coronary artery disease, the organization within the Division and the results of surgical treatment. These letters led to a meeting of Dr. Cameron, Dr. Macbeth, Chairman of Surgery, Dr. John Callaghan and me at which the major attention was given to Dr. Friesen's comments about surgical results. Statistics were reviewed and the matter was referred to the Medical Staff Advisory Board in January. It was unfortunate that Dr. Friesen's concerns had not been put before a joint meeting of the two involved divisions, a course of action which might have obviated Dr. Friesen's resignation which became effective in June.

In October 1971 we began negotiations with the Executive Director of the Charles Camsell Hospital, Mr. R.R.M. Croome, concerning a geographic full-time position in medicine at his hospital. Despite the generosity of the Camsell in providing the largest part of the proposed salary we still faced the difficulty of the "freeze" on hiring at the University. In June 1972, the Camsell promised to find two thirds of the salary, to provide office space and secretarial help and to make the appointee Chief of Medicine and responsible for the teaching unit in Medicine. With this attractive package in our hands we were able to secure permission to search for a suitable person.

We received a site visit in April 1972 from Dr. Gofton (Vancouver) and Dr. Kinsella (Kingston) who were here to review the support we were receiving from the Canadian Arthritis and Rheumatism Society. A matter to which I made reference earlier again came up for discussion. This was the question of Fa-

culty responsibility for providing a hard funded position for worthy staff members who had completed a fellowship/scholarship paid for by a voluntary health agency. I tried to explain the difficulty we faced in committing positions in advance, not knowing how many (if any) would be allotted to our Faculty and then to our Department. Added to this was the freeze on hiring which was not thawing yet. Both our visitors were experienced clinicians and Faculty members in their own Universities and were sympathetic to our problems. They recommended a final year of support for Dr. Percy which would conclude a five year term in 1973.

I met in May 1972 with Mr. Edward Dunlop, the truly remarkable blind war veteran who was the Executive Director of the Association for a number of years. As a result of this and a subsequent meeting with me and with Dean MacKenzie in 1973, an arrangment was reached by which a gradual transfer of responsibility to the university for Dr. Percy's salary would be completed in 1976-77. The Long Range Planning Committee continued to struggle with priorities which had become not just a matter of deciding which divisions would share the spoils but which of ten divisions might get the only available GFT position -- if it were to be unfrozen. In December 1971, they recommended that the order be: General Medicine, Hematology and Infectious Diseases. They also advised that conversions from soft funded positions be judged individually on merit. In June 1972 when Dr. Nihei's temporary funding from Muscular Dystrophy, the Division of Neurology Trust Fund and the Department terminated, the Divisional Directors strongly urged that he be allotted the full-time position which had become available. This was done.

The University Hospital began to take on increasing responsibility for staffing areas such as Intensive Care and this gave rise to a strong recommen-

dation from the Long Range Planning Committee that the "Chairman and the Executive Director of the Hospital clarify appointments between the Hospital and the University." The matter had been discussed at, although to my knowledge never referred to the College of Physicians and Surgeon of Alberta. Dr. Sherbaniuk sat as a member of Council and interpreted the mood of Council as one of resistance to arrangements whereby salaried physicians were creating income for the hospital through collection of fees for their services.

As stated earlier, the difference in concept between the administration of the Hospital and members of our Department was never resolved during my Chairmanship. The undisputed fact remained that the Hospital had better access to funds than did we.

In addition Dean MacKenzie looked at broad horizons and had less concern for details and subtleties of the foreground. As a consequence he adopted a pragmatic approach which left us without a spokesman at the level of top administration.

In the course of the year, Dr. Don Wilson made progress in the development of computer based, simulated patient management problems. Through his contributions to the development of the McLaughlin Examination Centre, Edmonton and our Faculty became the source for new computer-aided examinations for a widening circle of clients.

Meetings of the whole Department were held four times in the year and those of the Department of Medicine at the University Hospital continued to take place once a month at the conclusion of Grand Rounds. Representation continued to broaden at Faculty level and following the separation of the executive positions of the College and the Alberta Medical Association a representative from the latter was appointed to Faculty Council. The Glenrose Hospital also was represented on Council for the first time.

Remuneration to part-time staff became a matter of interest to the Alberta Society of Specialists in Internal Medicine in 1972. We had already attempted to measure the teaching contribution and had found it difficult to do. Hal Fearon developed a system which thereafter proved reasonably fair, acknowledging as it did, both rank and responsibility. The inadequacy of the amount available to the Faculty for stipends of the part-time teachers remained a problem for years to come. In June 1972 a memo to all staff included the following information concerning the stipends for part-time staff.

Rank	Honorarium
Clinical Instructor	$400 - 800/annum
Clinical Lecturer	$850 - 1200/annum
Assistant Clinical Professor	$1500 - 1850/annum
Associate Clinical Professor	$1850 - 2250/annum
Clinical Professor	$2250 - 3000/annum

Supplementary allowances were made for the following:

Administrative	$750/annum
Head of Unit	$750/annum
Teaching overload	$500/annum

The supplements recognized contributions of those who were Heads of Teaching Units, Divisional Heads and those with added duties in systems teaching.

ADMINISTRATION

1971-72 was the year of surveys. Hal Fearon, Administrative Officer drew my attention to a group within the University which was prepared to examine the organization of a department and make recommendations for more productive and effective activity. The Administrative Organization and Methods Survey was completed in the summer of 1971 and was presented to a meeting of the Department in September by Mr. Pirot. Their mandate had been to "identify any administrative or organizational problems which might exist, to develop alternatives and make recommendations including an implementation plan."

They interviewed all non-academic staff, most Divisonal Directors, and three quarters of the full-time academic staff; some part-time staff, the Chief Resident and student interns.

The report contained twenty-three recommendations. Our staff had been able to question the authors of the report when it was presented but I believed it would be helpful to me to obtain a detailed response question by question, and asked the Department of Medicine Advisory Committee to respond. In addition I requested commentary from each Divisional Director for the use of an implementation committee.

In his reply, Dr. Rossall pointed out the impossibility of satisfying recommendations which required either money or space (he was Chairman of the Dean's Building Space Allocation Committee and stated there was very little if any available). The Departmental Advisory Committee shared Dr. Rossall's pessimism about pursuing objectives, albeit worthwhile, without necessary money or space. They considered that the position described for an Associate Director of the Department was unworkable and would be unattractive to candidates. As an alternative they suggested appointing a physician on staff of the Hospi-

tal to be Chief of Medicine and another as Director of Research. There was agreement with the proposal to appoint a Medical writer, to review the mechanism of grant applications, to limit committee work and to take a number of other administrative steps. Many of these were subsequently accomplished. I was unable to obtain the necessary support from the Hospital administration to establish a position for a Chief of Medicine with responsibility for committee work in the hospital. The Dean was ambivalent.

The steady increase in work, both academic and clinical appeared to have strained the clerical resources of the Department. In an attempt to resolve problems which had arisen from "shared" secretarial arrangements, Hal Fearon arranged for an objective review of clerical workloads in the Department by Administrative Data Processing. Their report in April 1972 highlighted a number of difficulties.

Dissatisfaction existed among faculty and clerical staff because workload and services varied so much among the three categories of employee -- namely those paid by the University, those paid by the Hospital and those paid through research funds. The University restricted the Department to one steno for each two staff who had to be full-time University Faculty (or G.F.T.). The considerable number of our staff who were supported with soft money from voluntary health organizations, divisional funds or other sources had been made to feel they were equivalent to their G.F.T. colleagues. However, when the Department listed secretarial entitlement, they were not counted.

The reviewer stated "It is impractical, because of varying workloads, to effectively work within the restrictions placed on the Department by the University policy of half-time clerical assistance to Doctors." We agreed.

He observed that our clerical staff was becoming overspecialized and that they had come to believe that they were solely responsible to an individual faculty member. The practice of most of the clinical staff of augmenting the income of the clerk steno, he suggested, had a bad effect on morale and might be contributing to disparity in quality within the same classification, in addition to being inconsistent with University policy.

The review, I believe, proved useful to the Administrative Officer in providing him with supportive information to obtain authorization for another position from Personnel but more importantly to enable him to review with the Divisional Directors and their clerical staff ways in which the work load could be distributed more equitably. Hal Fearon's ability to handle and solve problems of the non-academic staff were appreciated by all of us, but particularly the chairman.

Reviews were most often instituted by us and those initiated by others were not always well received. In May 1972, we experienced our first request for information from Institutional Research of the University, a body which was charged with making statistical sense out of data collected from disparate departments through the University. My exasperation at attempting to get information to satisfy their needs was plainly reflected in my letter to Dr. Cameron, copied to other Chairmen. It read in part "It has been time consuming and generally futile ... the categories which are designed for the rest of the University seem inapplicable to the majority of the members of our Department ... data produced are not only inaccurate but misleading."

Perhaps the only good arising out of this outburst was a review of the way student contact and teachings hours were to be calculated in our Faculty which resulted in more satisfactory reporting for clinical departments. Insti-

tutional Research has otherwise survived intact long after my Chairmanship ended.

BUDGET

Our Departmental budget for 1971-72 ($499,076) had increased 14.8% over the previous year, the greatest part of this being consumed by inflation. As we prepared for 1972-73 we faced serious problems. Not only was there no added money to meet our planned growth, but we were unable to meet added inflationary costs, such as mailing, telephone, repairs and maintenance with a 1972-73 budget ($495,437) reduced by 0.7% from that of 1971-72. It was under circumstances such as this that a Chairman truly appreciated the good judgment and steady hand of his Administrative Officer who was able to write in the Department's annual report for 1971-72 that "Budget restrictions were such that very little growth was possible, but sufficient resources were available to meet all departmental commitments."

RESEARCH

Funds for research were becoming more difficult to obtain and our Divisional Directors were startled and upset to learn that six research directors had received notice of terminal grants from national agencies (Blain, Fawcett, King, Nihei, Percy and Weinstein).

In an effort to make certain that grant applications were as well designed as possible plans had been made in 1971 to employ a part-time editor through funds from Excess Earnings. The editor was to "constructively criticize with respect to editorial style, grammatical structure, clarity and spelling". We knew of similar arrangements at the Mayo Clinic and the Toronto Gen-

eral and Children's Hospitals and hoped that it might prove helpful to our own staff.

Hal Fearon had reviewed the procedures for grant reviews within the Department with the hope that lead time could be reduced to a minimum. The initial screening was to take place at divisional level (by the Director), followed by examination by the Scientific Screening Committee of the Department (Dossetor, Lynne-Davis and McPherson) after which the application reached the Chairman for his signature.

The 45 days which was allowed for this process did not satisfy the desire of most applicants who preferred minimal interference with their grants as they made their way to the University Grants Officer and Graduate Studies and Research. To my disappointment the system which was designed to help was looked on as a hindrance and was modified to the point where it ceased to accomplish the original purpose.

During this year, Drs. Alex McPherson and Harry Hyde began work with carcinoembryonic antigen and Dr. Pierre Band continued to work as a member of the Eastern Cooperative Oncology group. Dr. Overton and the Division of Respiratory Diseases made progress in the development of computer applications to pulmonary function studies with Xenon. Research also continued in Neurology, Nephrology, Endocrinology, Gastroenterology, Rheumatology, Cardiology and Infectious Diseases.

Publications numbering some 39 and 6 abstracts were recorded. Our Department received a total of $357,476 in grants out of the Faculty total of $2.4 million.

ASSOCIATION OF CANADIAN PROFESSORS OF MEDICINE

At a time when Faculties of Medicine had Chiefs rather than Chairmen, and when committees were created sparingly, several prominent men in Canadian medicine, all leaders of their Departments, created what I understand was informally referred to as the 1957 Club. This met casually at the time of the meeting of the Royal College. It must have languished for a time because Dr. Don Wilson in 1970 or thereabouts said in a letter referring to its possible revival "(the 1957 Club) has not really operated in a viable or effective manner for a number of years."

In November 1971, a meeting of Chairmen of Medicine was organized by Drs. John Gemmell of Manitoba and Charles Hollenberg of Toronto at the Skyline Hotel in Toronto. The agenda consisted of residency programs and the development of new subspecialties; medical manpower and its relationship to residency positions; Medical Research Council policies; and the usefulness of further meetings of an Association of Canadian Professors of Medicine.

It was agreed that the opportunity to discuss matters of general interest and to act in common interest, as a group and with other bodies, justified planning for regular annual meetings. The next meeting was held at the Royal York Hotel, January 27, 1972 in conjunction with the Royal College meeting.

McGill had always recognized two teaching hospitals, granting them equal status. Although the Headship of the McGill Department of Medicine alternated between the Chiefs of Medicine at each hospital, they assumed that each hospital would be represented at the Association (Dr. John Beck and Dr. Douglas Cameron). Toronto believed that they also should have representatives from each major teaching hospital which they then defined as one where there was a full-time faculty member in charge of a teaching program. They greeted my

claim to a second representative with skepticism but I argued successfully that Dr. Gilbert was our full-time person who should represent the Royal Alexandra Hospital.

Other Chairmen attending at that time were: Dr. Ed Yendt (Queen's), Dr. Ramsay Gunton (Western), Dr. Louis Horlick (Saskatchewan), Dr. Lionel McLeod (Calgary), Dr. Robert Kerr (U.B.C.), Dr. B. Lanthier (Montreal) and Dr. J.M. Pepin (Sherbrooke).

Discussion at this meeting centered mainly around arrangments for the conference on Residency Training planned for Queen's later that year. Dr. Fraser Gurd from the Royal College took part in the planning and Dr. Yendt was designated chairman of the conference to which four official delegates (one a resident) were to be invited from each Medical School's Department of Medicine.

In September 1972, Drs. Gilbert, Sprague and I and Dr. Del Tusz, Chief Resident, attended this conference where useful presentations and discussion took place concerning:

The Role of the General Internist (Spaulding)
Core Training (Dick Rossall)
Training of Internist - the Final Two Years
Internal Assessment (Ross Langley)
Another View of Internal Assessment (John Beck)
Royal College Examinations (Donald R. Wilson)
Relation of Program Directors to the Royal College (Fraser, Gurd)
Manpower Needs in Internal Medicine (R. Gunton)
Inter-University Programs (Yves Morin)
Need for Training Programs which are Models of Future Practice (D.L. Wilson)

This was a list which well represented the pertinent problems facing Departments at that time. Many have remained relevant to this day. The representatives were not always of one mind. This particularly applied to matters concerning practice which differed from Quebec to Ontario to Western Canada. The exchange of ideas was helpful in seeing our situation in the broader Canadian context.

CHAPTER V

THE WORLD AROUND 1972 - 73

Canada's economy was said to have shown the greatest real improvement since 1966, but unemployment stood at an eleven year high of 7.1% in September 1972. A price freeze was imposed in the United States.

Many changes were soon to occur but in the summer of 1972, General Franco, Indira Gandhi and Edward Heath retained political power and Chiang Kai-Shek was elected to a fifth term as President of Taiwan.

President Nixon chose Spiro Agnew as his running mate in the November election in which he was to capture 49 states. Canadians showed their discontent by defeating W.A.C. Bennett in British Columbia after his record 20 years in office and in broader expression of disapproval returned Prime Minister Trudeau's Liberal government to office as a minority.

Mark Spitz won a record seven medals in swimming for the United States at the Olympics. Lester Pearson, Nobel Prize recipient and former Prime Minister, died in December 1972, as did former President Harry Truman. President Lyndon Johnson, the former American President who not only lifted dogs by their ears to make his will known but also treated Prime Minister Pearson to a similar display of Texan annoyance, died at 65 in January 1973. The artistic and entertainment community lost Picasso, Noel Coward, Sir Ernest MacMillan and Betty Grable. Medicine remembered two pioneer cardiologists: Louis Katz of the Cardiovascular Institute, Michael Reese Hospital, Chicago and Dickinson Richards of New York, the joint recipient with Andre Cournand of the Nobel Prize in 1956 for his contribution to physiologic studies of the human heart.

In June 1973, the Greek Monarchy was abolished. The University Hospital Annual Report characterized the past year as presenting "more than its share of difficulties".

ACADEMIC YEAR

1972-73

There was little encouraging news as we entered the next academic year. No relief was in sight from the budget reductions and no decisions were forthcoming from government concerning the Health Sciences Centre or the Centennial Hospital. It was difficult to accustom ourselves to a changed view of Alberta, from a place of unbridled expansion and development to one where spending was carefully assessed by a government more aware than its citizens that the bubble was about to burst.

THE FACULTY

In August 1972 a search and selection committee was established to look for a physician to fill a geographic full-time position created at the Charles Camsell Hospital. The Hospital had agreed to provide two thirds of the salary, an office and secretary and to appoint the selected person as Chief of Medicine and Head of the Clinical Teaching Unit. The Region was represented on the committee by Dr. O.J. Roth, Regional Medical Director, Department of National Health and Welfare, and the Charles Camsell Hospital by their Chief Executive Officer, Mr. J.P. Kingsley.

The choice of Dr. Charles Harley was a welcome one to me. "Chuck" was a graduate of this faculty in 1965 and obtained his M.Sc. working with me in 1969 as a research fellow. He then spent two years at the W.W. Cross Cancer Institute, with the rank of Clinical Instructor before moving to Calgary to practice. He took up his duties at the Camsell in December 1972. The foresight of the hospital in establishing the position, combined with the admirable choice of the first incumbent has served to make the Camsell a popular and indeed exemplary clinical teaching unit for our undergraduate and graduate students.

Dr. Harvey Rabin joined the Division of Infectious Diseases as a Clinical Fellow and Sessional Lecturer in July 1972. He was initially supported through the Canadian Foundation for Advancement of Therapeutics and held joint appointments in Medicine and Pharmacology. A year later he was appointed as Assistant Professor, once again with joint appointments.

Dr. Rabin obtained his medical degree from the University of Western Ontario in 1965 after which he pursued graduate training in applied therapeutics and medicine at the Montreal General Hospital until 1972, during which time he obtained his Fellowship in Medicine from the Royal College. He remained in Edmonton, making consistent and significant contributions to both departments in teaching, research and clinical care until he left in 1979, to accept a position at the University of Calgary.

In September 1972 I was pleased and relieved to have Dr. Leroy M. Anholt join the staff and assume responsibility for the Division of Internal Medicine. Dr. Sprague had devoted a good deal of time from his busy practice as a part-time member of our faculty, carrying on as Acting-Director since Dr. Richards left in 1970. My belief that general internal medicine should serve

as the major centre for teaching was not shared by a number of members of the department. In contrast to departments in some other Canadian medical schools, our growing number of subspecialists did not act only as consultants to general medical services but admitted to wards designated for their subspecialty. I recognized the need for subspecialty beds for specific investigation, but hoped that the majority of patients with multiple needs would be cared for by general medicine. The opposite viewpoint was expressed by some of our sub-specialists who believed that the University Hospital should be staffed by sub-specialists (in the Medical Department) and that they could function as general internists, taking on those duties in rotation on the teaching wards.

There was little doubt that the recently qualified subspecialist was capable of functioning and teaching in general medicine; there was less certainty that this could be well done five years later when he had spent most of his professional efforts in expanding his knowledge and skills in his own area. Even finding time to attend the rounds of other subspecialty services was difficult for the busy new staff member and "keeping one's hand in" the whole field of medicine was an unrealistic expectation of all but the most gifted and hard-working physician.

A second problem which became more obvious in later years was the lessening importance of the general internists in the eyes of the students and housestaff. If the subspecialists could fulfill all the functions of a general internist, where lay the future for the latter? Indeed in the seventies there was a reduction in the number of those who functioned as role models in general medicine in the Univerity Hospital and the arguments for the primacy of the subspecialist became almost self-fulfilling.

The family practices of men such as Drs. John Scott and Frank Elliott, Ken Thomson, Ted Donald had been combined with their skills as general internists and also areas of special interest. Such practices no longer fitted easily into a hospital which accepted responsibility for introducing new methods for investigation and treatment and was earning the reputation of a special referral centre.

It was against this background that Dr. Anholt took on the responsibility of re-establishing the importance of general medicine, both as a service to patients and a base for fundamental teaching. The practice of medicine in most of its forms has continued to change and in both urban and rural settings it is no longer the same as it was in the fifties or sixties. Nevertheless, there appears to be a need for the general internist, particularly outside the highly specialized staff of the two University hospitals and in the smaller urban centres. The University of Alberta Hospital is currently undertaking a third role study, evidence that many of the questions asked in 1972 have not yet been answered to everyone's satisfaction.

Our difficulties with defining the relationships of the physician employed by the Hospital continued. I believed that the Chairman (or Director) of the Department of Medicine in the Hospital should take part in any arrangments concerning the appointment of such people .. but this did not always occur. In May 1973 I wrote Dean Mackenzie protesting that negotiations with Dr. Ray Ulan and Dr. Don Silverberg had been carried out between these physicians and the hospital administration without including representation from the Department.

A better understanding led to Dr. John Read offering the chairman the opportunity to view and comment on the budget for the Hospital Division of

Medicine. My request that this include a discussion concerning the hard ceiling for physicians employed in our department by the Hospital led eventually to a useful co-operative arrangement in which our Administrative Officer and the Comptroller of the Hospital worked through arrangements which were then dealt with jointly by Dr. Read and the Chairman.

The College of Physicians and Surgeons of Alberta through its Council expressed its opinion concerning financial arrangements between the Hospital and full-time physicians in the following resolution:

"All physicians fees must be paid directly to the doctor concerned or into a trust fund administered by the participating physician/surgeon." It continued "Any overheads arising from the conduct of the doctor's practice must be on a fixed bases and not as a percentage of the doctor's income."

Although the latter point never gave rise to any problem I am not aware that the first recommendation was adhered to with respect to disposition of the funds -- nor indeed would it seem to have been possible under the attribution interpretation of Revenue Canada. However, professional fees were maintained in the Professional Services Trust and the College did not voice further concerns to my knowledge.

The necessity for clearly defining the duties and privileges of these new positions was evident when Dr. Garner King applied for admitting privileges. At that time discussions among the staff about "beds" was likely to arouse as much passion as a political argument. Garner's original terms of appointment had related only to his duties in the intensive care area and contained no guidelines with respect to an expanded role. The Medical Staff Advisory Board concluded that the one to two admissions per month envisaged by Dr. Sproule, Director of the Division of Pulmonary Diseases would not create problems for

the Long Range Planning Committee on Staff Appointments. This Committee had been concerned that departmental considerations were often being given primacy rather that the needs of the whole hospital.

Further to the whole matter of special care units, Dr. Mackenzie prophesized that the Western Provinces would develop unified concepts of both health care and education. Out of this he saw a co-operative arrangement through which special units would develop in each of the major centres to provide for the needs of the four western provinces in patient care and teaching. Although tentative discussions had occurred then and continued to do so in a sporadic fashion, little has evolved to this time, twelve years later.

In January 1973, the department Advisory Committee agreed with Dr. Wensel that his division of Gastroenterology was prepared for a full-time appointment and priority was re-arranged to permit a search for such a person as soon as a position became available. Gastroenterology had introduced a one-year resident training program which had met with Royal College approval. It was a division on the move, particularly in invasive investigations. That year saw the introduction of the duodenoscope and an 82% increase in biopsies.

THE UNIVERSITY HOSPITAL

In 1972 the traditional starched uniform of the student nurse gave way to polyester. There were other changes: Peggy Price, who had managed most of the problems of the Admitting Office, retired after 32 years; Dr. Ted Bell, Head of the Department of Clinical Laboratories since 1950 died in May 1973.

Ted had been confined to a wheel chair since 1954 but had directed the department in its development from a one room laboratory for urinalyses, hematology and a very few biochemical tests, to a large automated laboratory cap-

able of supporting all current demands of the clinical staff. The Department of Medicine had a closer relationship with the laboratory than any other clinical department. There were some differences of opinion. Reference has already been made to the criteria established for research laboratories in our department which carried out newly developed tests for diagnostic purposes. In other areas such as hematology, our clinical service saw a need to provide laboratory experience for their trainees and to have the opportunity to interpret bone marrow and peripheral smears on their hospitalized patients. Dr. Bell believed that his responsibility was to provide the final "official" interpretation on the chart. This was never settled to the satisfaction of the members of the Division of Hematology.

Dr. Wilson (who introduced radioactive iodine to this city) Dr. Watanabe and Dr. Crockford all acted at one time as consultants to the laboratory and provided for some time the special laboratory techniques in endocrinology not yet introduced into the service laboratory.

Probably because they were less tradionally related to clinical laboratories, electrocardiography was transferred to the Division of Cardiology and the Pulmonary Function Laboratory grew up in the Division of Respiratory Diseases.

The attempt by Dr. Blain in Neurology to obtain accreditation for the Neuromuscular Laboratory (and the right to collect fees) failed in February 1973 as a result of the opposition of both Dr. R.E. Bell and Dr. Gordon Bain who took the position that clinical pathology was a specialty recognized in the province and those who were not recognized as clinical pathologists should not run laboratories.

The Hospital sought to collect an outline of long-term objectives from each department. In the spring of 1973 we submitted our rather general out-

line which was returned for more specific information. We found this difficult to comply with because we faced uncertainty with respect to funding and space. In 1969 and again in 1972 each of our divisions had provided the Advisory Committee of the Department with long term plans. It was almost sadistic to ask what directors needed to pursue appropriate and reasonable goals and then to fail to provide the resources. The annual report of the Hospital in 1972 read: "1972 presented to the University Hospital more than its share of difficulties." The report of the next year was even less encouraging when it stated: "Problems have become more complex and difficult."

A problem which became apparent in the collected five year plans of the various hospital departments was that arising from the different goals. Some departments stated that teaching and research was their priority while others sought a position of leadership in patient care. The role of the hospital was not defined by the Board or the Administration. Without such guidance it was difficult for a department to develop and accept a plan appropriate for the hospital as a whole. No department chairman had an overview of the hospital and it was to be expected that each chairman would see the future in terms of his own department's goals and objectives.

The Long Term Objectives Committee of the Hospital had been formed in February 1972. Dr. John Read chaired the committee which consisted of Drs. D.F. Cameron, T.A.S. Boyd, W. Weinstein and R.J. Johnston. The Medical Staff Advisory Board had earlier expressed their concern about the addition of new staff in the absence of long term plans.

Neither the submissions by the departments nor the work of the Long Term Objective Committee appeared to leave us much further ahead with rational planning for hospital staff.

Advantage was taken of the nursing shortage to close MP8 in December 1972 for renovations. By March 1973 the standard of safety in the Mewburn Pavillion became a matter of concern to the Board. In addition to the acknowledged fire hazards, the wards lacked piped in oxygen and suction. The Mewburn also lacked female beds. Renovations were planned to rectify these deficiencies but in the meantime our department had to face a reduction in beds.

UNDERGRADUATE TEACHING

Three years had passed since the new curriculum was introduced. The last of the students to have been enrolled in the old curriculum graduated in the spring of 1972. During the 1972-73 year no major changes were made to the teaching program but we tried to improve the organization in Phase III.

Two new clinical teaching units were established. Up to four students were assigned to each of these at the W.W. Cross Cancer Institute and the Charles Camsell Hospital. This permitted Dr. Sprague to reduce the number at the University Hospital to twelve. The Royal Alexandra Hospital was assigned six and the Edmonton General and Misericordia Hospitals each had four students. The undergraduate internship in Medicine was divided into two eight week services, the first of which was spent at either the Royal Alexandra or University Hospitals in the expectation that the close supervision available in those hospitals would better prepare them for the other rotations.

When the curriculum was designed it was recognized that certain material would inadvertently be left out or that there might be need to re-enforce teaching which had taken place earlier. The "whole class" time set aside on Wednesday afternoon was meant to serve this purpose. The pie of instructional time was of limited size and what was set aside on Wednesday afternoon had to

be "taken" from the student's time on the wards. It was necessary to insist firmly that students be relieved of ward duties and that teaching rounds on the teaching units not interfere with the commitment to whole class time.

The electives program for students in Phase III was organized through the Dean's Office and in 1972 was the responsibility of Dr. D. Cooper Johnston. Our department was making a significant contribution to the provision of electives and I believe most of our staff competed enthusiastically for students and enjoyed the closer relationship they could develop with them. Although one might suggest that having a student for an elective might increase the likelihood of such a student choosing that specialty for graduate training, I know of no evidence to suggest that this did occur. In fact more than one student doing an elective with Dr. Joe Dvorkin later said the experience had decided him against cardiology because he had no wish to work so hard for the rest of his life!

Electives took time and effort of the supervisor. We recognized that we were not able to credit our staff with this contribution because it was a "faculty" not a "department" program. This gave rise to a minor degree of discontent in that some of our teachers considered that their teaching load was not being appropriately acknowledged.

In February the Faculty Council approved the introduction of a newly designed course to teach physical diagnosis and to orient students to hospitals before the start of Phase III.

Phase II was re-examined and it was decided by the Phase II Committee that a modified block system of teaching would be introduced in 1973-74. Because the outpatient clinic in Dermatology was discontinued in November 1972, plans were adopted to teach this subject as an elective in Phase III to be taken in the downtown offices of dermatologists.

The results of examinations by the Medical Council were better in 1972, although Dr. Goldsand in a letter of September 1973 to Dr. Kling, Director of Graduate Training, expressed his concern that in Phase III there was "insufficient supervision by attending and resident staff" and argued that we needed more residents to teach on the wards.

In June 1973 the Faculty established an Academic Appeals Committee which provided a body to which students could appeal if they were dissatisfied with the decision of the Student Evaluation Committee. Student representatives were added to the Phase II Test Committee and the Medical Students Association sought representation on the Academic Standing Committee. As Chairman of the Curriculum Committee, Dr. Rossall reported to Faculty Council in May 1973, and concluded by saying that the new curriculum was reasonably established although "the maggot has not yet become the butterfly."

GRADUATE TRAINING PROGRAM

Both the quality and quantity of residents continued to arouse serious concern. In a teaching hospital there is probably no subject which causes more anxiety and worry than a threat to the supply of competent and well-motivated housestaff.

In September 1972 I again wrote Dr. Kling to argue that our department should be entitled to a larger share of the limited number of graduate training positions authorized by the Hospital Services Commission. I observed that the subspecialty of Orthopedics had one third of the total number of residents that Medicine had and asked that future re-distributions of positions reflect the requirements of the province and country as established by the several committees looking into medical manpower. We remained at our previous allotment of 33 positions for Medicine and 53 for Surgery.

In November 1972 Western Canadian Professors of Medicine met in Calgary. Dr. John Gemmell (University of Manitoba), Dr. Robert Kerr (University of British Columbia), Dr. N. Beck (University of Saskatchewan), Dr. Lionel McLeod .(University of Calgary) and I spent the day discussing graduate training. It was agreed that more exact data concerning medical manpower was required. We acknowledged the importance of training programs in medicine and its subspecialties in attracting and retaining "high quality faculty". We recognized a threatening problem in the action of most of our Provincial governments in curtailing residency programs in the face of the unlimited immigration of trained medical specialists permitted by the Federal government.

The total number of trainees in the five western departments of medicine was 145 but this included an unspecified number who were taking medicine only to change to another specialty, using their training in Medicine as a credit in another discipline or toward licensure.

Manitoba had nine accredited training programs in subspecialities of Medicine, Alberta was next with seven and British Columbia had six. Saskatchewan had an interest in several but had only two then recognized. Calgary's program was in its infancy but categorized eight subspecialties as under study or of interest.

The five schools represented agreed that the accrediting system should be tested by a submission from a multi-university group proposing a training program embracing more than one centre. I am uncertain, nor does Dr. McLeod know, why this proposal never progressed.

In April 1973 I arranged for the creation of a new Graduate Training Commitee, the membership of which consisted of Drs. Gilbert, Anholt, Goldsand, Sprague and the Chief Resident. The Committee was instructed to meet monthly

and to be responsible for the selection, assignment and procedures for evaluation of all medical residents. They were also to ensure that the educational needs of the trainees were being met and that service to patients was appropriately arranged for. This committee succeeded an earlier one consisting only of Sprague, Fraser and Anholt. The new committee was chaired by Dr. Goldsand and Dr. Sprague retained the position of Program Director.

The Medical Graduate Society had written a report on the Resident Training Program in 1972-73 and among the several appropriate recommendations had asked that a Resident Training Committee be established in each program. These would comprise a director, a representative(s) of geographic full-time and part-time staff and housestaff. They urged that each committee be responsible for producing a "core program and a syllabus, and arrange for pre-examination instruction and assessment". At that time there were only two approved programs in our department, namely General Internal Medicine and Neurology. Cardiology had made application in 1972 and Gastroenterology and Clinical Hematology were being assessed for accreditation in the Spring of 1973.

The On-Site Survey of Specialty Training Programs by the representatives of the Royal College (Dr. E.R. Yendt, Medical Specialities and Dr. J.F. Lind, Surgical Specialties) took place April 9-13, 1973. Dr. Yendt complained in his final report, which was to be considered by the Committee on Evaluation of Specialty Training Programs at its meeting in May 1974 that he had been able to spend only five and one half hours in review of all Medicine and Medical Subspecialties. Included with the Department of Medicine in this grouping was Pediatrics, Psychiatry, Rehabilitation Medicine, and Radiology-Diagnostic and Therapeutic.

Dr. Jack Sprague and I met with Dr. Yendt and representatives of the Liaison Committee of the American Medical Association and the Association of American Medical Colleges, the Canadian Medical Association and the Association of Canadian Medical Colleges. The Liaison Committee was interested in the undergraduate teaching program and the Royal College in the Graduate Training Program. No minutes were kept for us and I am unable to remember any details of the interview except for a question about our arrangement for providing appeals against the In-Training Evaluation of Residents.

Because the report was an expression of the opinions of the supervisors of a graduate trainee, I stated that I thought it made no sense to ask the same department to provide a route for appeal. I went on to say that if the trainee considered the report to be unfair or inaccurate he should register his complaint with the Royal College who then would have the responsibility to initiate some type of impartial investigation of his grievance. Any in-house review would tend to evolve into dispute with the winner being he who could muster the largest number of allies. Logical though my argument seemed to me (as it still does to-day) I did not convince Dr. Yendt and the Director of Graduate Training soon introduced mechanisms for appeal into all programs.

Another point which perhaps arises out of this discussion is that until 1972 or so the Graduate Training Program in our Faculty had remained a faculty project, very much as it had started in 1946 under the firm guiding hand of Dr. Mark Marshall. Departments were satisfied to leave most of the management to the central organization which, under both Dr. Marshall and his successor Dr. Dick Rossall, ran smoothly and with a minimum of demand on departmental resources.

A second administrative arrangement intervened in the relationship between the department and the resident-staff. Until Dr. Sam Kling took over the directorship of Graduate Training the University Hospital, through Dr. Read's office, kept the records of all housestaff. Until the introduction of the In Training Evaluation by the Royal College, all evaluations were collected and stored by the Medical Director of the Hospital and the Housestaff Secretary who worked for him. Record keeping and other matters pertinent to the training programs were out of the control of the responsible department and were not even available in the office of the Dean. After Dr. Kling took up his duties in July 1972 he set the stage for the eventual transfer of these functions to the faculty, by setting up a duplicate of the resident files.

The recognition of sub-specialities in Medicine by the Royal College in the seventies added to the complexity. In addition, by increasing the number of programs, program directors and committees, the change in administrative style from a paternal autocracy to a "participatory democracy" (as proposed by Pierre Trudeau in the national context) occurred with a rapidity which outstripped the efforts of many of us who should have been developing newer "management" methods.

For unexplained reasons the final report of Dr. Yendt was not received by the Dean until more than seven months after the visit in April. Discussion of the report and its recommendations will be deferred until we reach the final year of my tenure (1973-74).

In the spring of 1973 the Hospital Services Commission requested a projection of the graduate positions which were to be funded through the next five years. A meeting took place June 5, 1973 with the following persons present: Robert Woolstencroft and Roy LeRiche (College of Physicians and Surgeons of

Alberta); C. Varvis and D. McAlpine (Royal Alexandra Hospital), B. Snell and J. Read (University Hospital); J. Anselmo and J. Lipinski (Edmonton General Hospital); C. Gravett and D. Macgregor (Misericordia Hospital); D.F. Cameron, L.C. Grisdale and S. Kling (Faculty of Medicine). They recommended that first year positions (72) and residents (176) remain unchanged to 1978-79. Changes were foreseen in the second year to accommodate more trainees in family practice and others seeking licensure. Licensure in Alberta as of January 1976 required two years of post-graduate training. This resulted in an increase in predicted positions required in second year from 25 in 1974-75 to 82 in 1978-79.

It was disappointing to find that the committee, made up of representatives of all our teaching hospitals, our Director of Graduate Training and two representatives from the Office of the Dean, had failed to recommend any increase in the resident establishment which was plainly inadequate to support our undergraduate or graduate programs.

On the basis of initial oral reports of the Royal College Survey, Dr. Goldsand set about planning for adequate opportunity for residents to gain experience in ambulatory care. In two programs (Cardiology and Gastroenterology) this was attempted through inviting the residents to take part in the private referred practice of faculty members.

Dr. Goldsand in a letter to Divisional Heads, June 11, 1973, emphasized our difficult position when he wrote that seventeen residents would be on subspecialty services in the next academic year while the remainder (some 13) would be assigned to the Teaching Units. He added "The present situation has unfortunately necessitated the assignment of resident duties to be primarily based on service rather than educational needs."

He then requested a list of objectives of each program and the duties expected of the resident, thereby introducing some purpose for the existence of program committees.

In an attempt to provide residents who were rotating through subspecialty services (as they did in 18 months of their 24 "core" months) with as wide an experience as possible in the ten services, the rotations were limited to 2 months. It was admittedly difficult to gain a great deal from such an abbreviated tour of duty and the divisions asked that rotations be lengthened to 3 months. Like many similar choices one had to recognize that depth of experience was being purchased at the expense of breadth.

The Graduate Training Committee carried out a useful investigation to determine the opinion of residents concerning the short-comings and the success of medical services. Four services were judged to be satisfactory. Criticism of others included comments that they were "too service oriented", ward attendance of staff was irregular, that there were too few patients and that a laboratory was needed on the ward. Divisional Heads were made aware of criticisms and encouraged to seek solutions to the problems. The major contributing cause to many of the difficulties - too few positions for graduate trainees - remained unsolved for 1974-75.

We entered the New Year with a Faculty Council meeting January 11, 1973 at which we were told that the projected deficit for the University for 1973-74 was $1.82 million.

PRACTICE PLAN

The advantage of group practice had persuaded the members of several divisions to develop ways of sharing clinical responsibility and income. There was some support growing within the department in 1970 for an extension of practice plans with the hope that a departmental plan could eventually embrace all divisions, incorporating the best features of the existing ones.

An appreciation of the situation regarding professional earnings, including a historical background and some suggested approaches to a departmental practice plan was circulated to the geographic full-time staff in May 1970 (Appendix A).

In the 1971-72 academic year a committee consisting of Dr. Adam Little (Chairman) Drs. B. Sproule, M. Watanabe, F. Weinstein, D.R. Wilson and A.M. Edwards began work on a proposal to be placed before the G.F.T. members of the department. Information was collected from other medical schools across Canada and the United States and most of that winter and spring was spent in discussing the application of the experience of others to our own situation. In the spring Dr. Little relinquished the chairmanship to Dr. Lee.

In addition to information from elsewhere we examined the state of the departments professional activities. In 1971-72 eight members contributed a total of $22,696 to excess earnings. This was approximately equivalent to the minimum salary proposed for an assistant professor.

The Committee's report was sent to each G.F.T. member of the department and to those employed primarily by the Hospital in September 1972 (Appendix B). Although the recommendations were reasonably specific it was agreed at a meeting of those participating and at a meeting with the part-time staff that advice from experts in management was desirable. Another reason for agreeing

to employ outside consultants had surfaced several months earlier. The Committee, then under the chairmanship of Dr. Little had sought to obtain information concerning the total amount earned in professional activities by members of the department. This was essential to any responsible planning. Despite our offer to receive anonymous reports we met with adamant refusals from some to divulge this information to anyone except an outside, disinterested party. The Committee had a part-time staff member (Edwards) and the plan was to make provision for membership of any interested part-time faculty. We sought and received their support.

Two men who were in partnership and who came to us recommended by a member of our staff were chosen from several suggested names. Their eager start deteriorated in 1973 into unfilled promises of overdue reports; the partnership then dissolved. We were left with one of the original consultants who assured us that he would complete the task.

The impetus which had been present in the department had, by the Spring of 1974, largely dissipated. Members began to voice reservations about some fundamental assumptions of the practice plan. To my great disappointment it became obvious that we had missed the tide of opportunity and that the issue could not be revived with any hope of success before a new chairman took over. In retrospect we should have obtained a commitment from the participants in September 1972 and asked for help from management consultants after establishing a preliminary working framework. Only now, some twelve years later has there been any further interest in a general practice plan and it remains to be seen whether the well-established divisional plans can be successfully incorporated into a departmental or faculty unity.

ADMINISTRATION

The financial situation had not improved for 1972-73 but the optimism of Hal Fearon was reflected in his contribution to the annual report which read "a satisfying year with some growth in spite of a static budget".

It had become apparent that departmental administration could be carried out more effectively if some division of duties could be arranged between the Chairman and an Assistant Chairman. The recurring suggestion that the Chairman of the Department of Medicine of the University Hospital be separated from that of the Faculty had run into difficulty and opposition as explained earlier. Nevertheless there were other clearly defined areas such as Research and the Undergraduate Teaching Program which merited more attention than one person could give when faced with the ever-broadening horizons of responsibility devolving on the Chairman.

Dean Mackenzie agreed to a trial period from November 1972 to April 1973. In his letter to me he wrote "If, on April 30, 1973 ---- you are of the opinion that the pilot study has worked out well, we will put the appointment through the University, to make it official, with the recommendation that a portion of your honorarium as Department Head be paid to the Assistant Chairman ----."

The financial inducement was not great — a third of my honorarium ($1500). Armed with a reward of $500 and whatever kudos might be attributed to the position I tried to persuade three people to accept this position. Neither the stipend nor the challenge of tackling our ample supply of problems was enough to attract anyone of the three, all of whom were busy in their own right.

The administration of the department continued to be the responsibility of the Chairman, his Administrative Officer and two secretaries. Not to be forgotten were the continuing contributions of the divisional directors and the Advisory Committee.

Dr. Ludwig Sherman had joined the Advisory Committee at the conclusion of Dr. Eidem's term. He served for two years and attended a meeting a short two weeks before his death. He had allowed his increasing disability from a nephroma to interfere little with his large practice as an internist at the Royal Alexandra Hospital and as a widely-read and popular teacher of the interns and residents. Dr. Chris Varvis succeeded Dr. Sherman and served until the Committee was disbanded in 1973.

The attempt to use city-wide meetings of the department four times a year to increase the sense of involvement in departmental affairs had not met with success. We had failed to interest a significant number of our part-time teachers and indeed had a disappointing turn-out of our G.F.T. staff at meetings held in the three other hospitals. When the attendance decreased from 80 at the first meeting to 32 and 36 at the final two meetings of the year in 1972, it seemed sensible to revert to two meetings annually in 1973-74.

RESEARCH

The Department attracted $1,147,260 in research funds from all sources in 1972-73. Dr. Mo Watanabe accepted the task of Coordinator of Research for the Department. To help him in his work a full-time secretary was hired with trust funds.

The Department was supported by grants from the National Cancer Institute, National Health and Welfare, the Heart Foundation and Canadian Arthritis

and Rheumatism Society as well as the Medical Research Council. The Special Services and Research Committee of the University Hospital gave support amounting to $20,737.

Progress was made in the proposal for a Ph.D. in Medical Sciences which has gained support of the Dean of Graduate Studies and Research and the Academic Development Committee. It remained for it to be approved by General Faculty Council and the Provincial Appraisals Committee.

THE BUILDING PROGRAM

Representatives of the Hospital Board, after meeting with the Minister and the Health Sciences Centre Authority, reported rather gloomily that "The Government's reaction to our project is very disappointing."

The Chairman of the Alberta Hospital Services Commission in the fall of 1972 appointed J. Graham Clarkson as special advisor to the Minister but otherwise gave us little encouraging news concerning the Health Sciences Centre.

Graham Clarkson's mandate was to study the needs of the University of Alberta Hospital and the Faculty of Medicine for additional facilities as planned in the project. He was further instructed to "take into account the needs of the Province of Alberta and the resources of both the Edmonton and Calgary campuses ---. He will review the possibility of integrating the health resources of the western provinces to meet the needs of Western Canada".

This information was contained in a letter of August 30, 1972 to the Chairmen of the clinical departments from Dr. Snell, Executive Director, who went on to predict that Clarkson's review would take a year to eighteen months and that "the facilities will not exist for years."

Twelve years later the first phase of the Health Sciences Centre was opened by Premier Lougheed. A new committee system was introduced by the Minister (Crawford) in March 1972 with the power vested in the Health Sciences Centre Authority, on which six cabinet ministers served. At the same time he dissolved the University of Alberta Health Sciences Co-ordinating Authority and its Planning and Development Committee. This now disbanded committee had comprised the Deans of Dentistry, Pharmacy and Medicine, Directors of the School of Rehabilitation Medicine and Nursing, the University Vice-President Planning and Development and Dr. Bradley, Chairman of the Hospital Services Commission.

In addition to the newly created cabinet committee there was now a University of Alberta Health Sciences Planning and Development Committee on which sat J. Hunt, Director of Design and Conscruction of the Department of Public Works (Chairman), Dr. Snell, Executive Director of the Hospital, J.R.B. Jones, Capital Planning Officer of the University Commission, Dr. W.D. Neal, Vice-President Planning and Development of the University and Dr. Bradley. It was on this committee that the responsibility for planning now fell.

For more than 2 years the Hospital had witheld requests for upgrading and many needs were urgent. After representatives from the Hospital met with the Minister he agreed to authorize up to $1 million for "immediate, essential needs." Renovation of the Mewburn was completed.

At that time the Hospital had a total of 1300 beds (the Aberhart Hospital contributed to this total). Medicine was recorded as having 288.

Various other aspects of planning were continuing. Dr. Grisdale chaired the Educational Clinical Support Facilities Committee (G. Bain, T.A.S Boyd, E. McCoy and P. Crockford) which wrestled with the problem of finding conference and teaching rooms in the existing space.

An ad hoc committee on Support Facility Requirements was established to assess the urgent needs of the obsolete buildings. (I believe a third Committee was chaired by Dr. Read). In October 1972 the Butler Building (a temporary structure facing on to 114 street) was vacated by Pathology and Bacteriology. It was proposed that this be used for ambulatory care to compensate for the delay in the "Centennial Hospital".

At the end of 1972-73 many of us felt as if we were expending all our energy to avoid losing ground on the treadmill of inflation, recession, procrastination and delay. It had not been an encouraging year.

CHAPTER VI

THE WORLD AROUND 1973-74

A sense of uneasiness seemed to pervade the country. Real growth in the gross national product declined further and unemployment showed little change. A strike of railway workers was terminated by Parliament.

Many countries were struggling with the worldwide energy crisis arising from rapidly increasing prices and a boycott of some nations by O.P.E.C. producers. The United States was angered by the application of an export tax on Canadian oil, but most Americans focussed their attention on the Watergate trials after witnessing the resignation of Vice-President Agnew brought on by a charge of income tax evasion.

By the spring seven campaign workers and White House officials had been indicted on charges of conspiracy and obstruction of justice and President Nixon was forced to release the transcripts of tapes which led to his unprecedented resignation in August 1974.

Kissinger shared the Nobel Peace Prize with the North Vietnamese negotiator Tho for bringing that unhappy conflict to an end. Israel and Egypt waged war over the Suez Canal and the Sinai.

In May 1974 Trudeau's minority government was defeated over John Turner's budget.

This year saw the death of Vannevar Bush, the inventor of the electronic analogue computer and the wartime director of the Office of Science, Research and Development in Washington. The world lost Duke Ellington and Hollywood

Sam Goldwyn. Juan Peron died after serving again as President of Argentina. General Guy Simmonds who led Canada's 1st and 2nd Divisions with great distinction died at age 71.

The medical world recognized the contribution of Karl Meyer, the virologist who isolated the cause of equine encephalitis and who lived to be 90. Earl Sutherland, Nobel Prize laureate for his isolation of A.M.P. at Western Reserve Medical School, died at 59. Paul Dudley White, perhaps the most noted clinical cardiologist of all time in the United States died on October 31, 1973.

Pioneer 10, an unmanned space craft reached its nearest point to Jupiter after 21 months travel and those waiting for an answer to the future of the Health Sciences Centre wished for a comparable happy confluence of events.

THE ACADEMIC YEAR

1973-74

The hope that recession and inflation were temporary ills gave way to resignation and to a different and more restricted set of goals. Mixed with this acknowledgement of our new lot were the frustration and disillusionment of those not directly involved in planning and administration — those who were affected by the decisions but who could not identify the source of their discomfort.

In his departmental report that fall to the Medical Staff Advisory Board, Dr. Robert Macbeth, Chairman of Surgery who had just returned from a

sabbatical leave concluded by saying: ". . .the overwhelming impression that one gets on returning to the University Hospital after a full year of sheltered life while on sabbatical is that the natives are restless and that the problems are many and increasing rather than diminishing".

By the end of the academic year some problems seemed to be on the way to solution although sufficient remained to challenge the next chairman. In September 1973 I wrote Dean Mackenzie to confirm my intention, stated at the time of my appointment, that I did not wish to be considered for a further term.

UNDERGRADUATE EDUCATION

The new curriculum had been through its initial and major changes and only administrative readjustments were made in 1973-74.

Student representation on Faculty Council was increased from four to six and four representatives were added from graduate students in Basic Sciences.

No clear result emerged from a referendum of students concerning Pass-Fail marking. Their ambivalence was shown in the desire of the majority to adopt this system but to retain their personal right to get marks. In a similar vein the students asked that class rank be omitted from the official transcript but that it be available on request.

The University Hospital continued to serve the largest number of student interns. Dr. Anholt redesigned the teaching wards into four services, each having two preceptors, a Junior Assistant Resident and four students. A Senior Resident was responsible to two services. Subspecialty services were represented on each teaching unit. The adoption of this orderly arrangement made it easier to monitor the content of the program and the progress of the students. Students from this rotation spent their second eight weeks at

either the Cross or the Charles Camsell Hospitals. A similar arrangement for students from the Royal Alexandra Hospital saw them take their second rotation at the Misericordia or General Hospital.

Block teaching in Phase II began in September 1973 and relieved the many involved members of the Department of Medicine of the previous onerous repetition of courses throughout the year.

GRADUATE TRAINING PROGRAM

The arguments which our department had put to the Director of Graduate Training and others over the past four years continued. In September, Dr. Goldsand, Chairman of the Graduate Training Committee sent a detailed ten page letter to Dr. Kling, Director of the Division of Graduate Medical Education. In this he put forward our need for 70 graduate trainees (20 interns and 50 residents), based on educational and service needs arguing once more that our establishment was unrealistically small when compared to other departments.

Whether it was the cogency or the repetition of these arguments matters little but the result was a promise from Dr. Kling to provide the Department of Medicine with 50 positions for 1974-75 (12 interns and 38 residents). This was an appreciable increase over the 33 which we had to date and although the numbers were still insufficient to establish a pyramidal system in each training program it at least ensured the continuing existence of graduate training in our department. The shortage was unrelieved in 1973-74.

Dr. Goldsand and his committee had hoped to re-organize the ward system to encourage graded responsibility for the housestaff and appropriate supervision and teaching of the junior members. The long-standing problem of inadequate numbers had yet to be solved and in a letter to divisional heads

(October 19, 1973) he wrote "The plan is unworkable if the currect restrictions on numbers of house staff remain". It did.

The requirement of the College of Physicians and Surgeons for two years of post-graduate training for licensure in the Province effective January 1, 1976 gave rise to concern that it might discourage straight internships in Medicine as suggested by Dean Mackenzie who described the regulation as a backward step. Dr. Goldsand sought and received assurance from Dr. LeRiche that a graduate trainee who had completed a straight internship in Medicine could complete his requirement for practice by taking an appropriately planned rotation in a second year.

In 1973-74 internships remained as hospital programs. The Royal Alexandra Hospital had a popular rotating internship (26 positions) but refused to consider applications for straight-internships in Medicine unless preceded by at least six months rotating experience. The University Hospital, as seen by its Education Committee and by several department chairmen was increasingly unattractive as a place to gain uniformly good experience in the major disciplines. This was in part owing to the increasing proportion of patients who were referred for special investigation and care and the ill-defined separation of the student intern from the intern in ward duties and instruction.

In January 1974 the Hospital was informed by the Canadian Medical Association Committee on Intern Training that the program was no longer accredited. This was done without warning or explanation. After protesting the decision the Hospital was permitted to retain 18 positions for straight or mixed internships although it was not approved for training in Family Practice. In July 1974 the Family Medicine Division and the Family Clinic moved to its present home in the Royal Alexandra Hospital.

The Department entered the 1974-75 year with 43 housestaff which permitted the organization of four adequately staffed teaching units -- two at the University Hospital and one each at the Royal Alexandra and General Hospitals. We had hoped to have six clinical teaching units. Small numbers of students were assigned to the Cross, the Charles Camsell and the Misericordia Hospitals and student interns were taught on Neurology services in three hospitals.

The Medical Graduate Society produced a report on the program in graduate training which proved helpful in trying to correct some of the deficiencies. Their representatives on the Executive of Faculty Council expressed their disappointment in the Accreditation report of the Royal College claiming that it omitted suggestions from the residents. Dr. Lorne Tyrrell, Dr. Roger Amy, Dr. Jim Piercey and Dr. Jamieson sat as representatives of the housestaff on the Graduate Medical Education Committee of the Faculty.

By the end of the year, Dr. Anholt produced for the first time a pamphlet for distribution to prospective trainees entitled "Residency in Internal Medicine."

ACCREDITATION BY THE ROYAL COLLEGE

The report of Dr. Yendt resulting from the on-site visit of Apirl 1973 reached the Dean at the end of November. It was critical of the Department of Medicine and referred to serious problems in the residency training program. He thought that morale in the department was low.

Specific deficiencies which he identified included a lack of experience in ambulatory care, a lack of supervision of residents and a failure to provide graded responsibility. Some programs were too heavily involved in providing service. He stated that he "--- could not help but gain the impression

that the major effort devoted to revision of the new undergraduate curriculum and its introduction has so overtaxed the manpower and resources of the faculty that time and thought devoted to the residency program have suffered as a result."

He also added the observation that certain physical facilities in the University Hospital compared very unfavourably with those in some of the other institutions.

Other criticisms included: the inadequacy of affiliation agreements between the Faculty and the teaching hospitals which preclude the development of optimal residency training programs; the inadequate number of full-time teachers and particularly their scarcity in the affiliated hospitals; the lack of an appeal mechanism from in-training evaluations. The recommendations he made to the Committee on Evaluation of Specialty Training Programs of the College consisted of:

(1) Neurology - provisional full approval for 2 years which would then cease if out-patient experience did not become adequate.

(2) Cardiology - approval-the proposed out-patient experience was acceptable to the Sub-Specialty Committee.

(3) Gastroenterology - the same.

(4) Hematology - approved

(5) Internal Medicine - probationary approval for 2 years.

Dr. Yendt recommended that the Department plan a retreat to discuss its various problems and this was done.

It was apparent, at it is with most on-site accreditations, that the observations made by the visitor reflected the complaints and suggestions of the staff with whom he met. It is helpful to have this mirror to provide such

information as well as observations concerning matters such as relationships between the Faculty Administration and the affiliated hospitals. As Dr. Yendt emphasized his task was not an easy one when one recognized that he reviewed five programs within the Department of Medicine and five other medical specialties in five hospitals in three and a half days.

THE RETREAT

A retreat of 34 members of the Department, divisional heads and certain others, was held at the Jasper Park Lodge, February 9-10, 1974. The arrangements were thoughtfully and carefully made by Dr. Adam Little. The agenda was agreed to by the Divisional Heads and covered the following subjects:

1. Problems as seen by the Department Chairman (Fraser)
2. The Department and its Affiliated Hospitals (Gilbert)
3. Problems in Hospital Relations and their Possible Solutions (G. Clarkson)
4. Department Practice Plan (H.G. Moncrieff)
5. Departmental Teaching Programs (Goldsand)
6. Graduate Teaching (Tyrrell, Freeman and Rorstad)

The afternoons were given over to group discussions and probably most important of all, the formulation of action or solution to problems.

Apart from Graham Clarkson, the Project-Director for the Health Sciences development and Mr. H.G. Moncrieff, consultant to the Department concerning the proposed practice plan, all other persons attending and entering into the discussions were persons with various responsibilities in the department. It was indeed, an overdue and useful examination of our problems. The solutions were not so easy to design since some of the crucial matters were not within our power to change.

The five major recommendations of the meeting were:

1. To seek new affiliation agreements with the teaching hospitals (to permit a more direct influence of the University on such vital matters as the appointment of the Chief of Medicine and the placing of additional full time staff in these hospitals).
2. To separate the chairmanship of the department into two positions, one of which would be responsible for the academic faculty of the Department throughout the city and the second of which would bear responsibility for the Department of Medicine within the University Hospital.
3. To support the establishment of a department practice plan.
4. To support the establishment of clinical teaching units in which graded responsibility could be delegated to the housestaff.
5. To support the need for ambulatory care facilities with a director appointed from the Department.

The frank and full report to the meeting by the three residents concerning the graduate training program drew attention to a number of shortcomings which were departmental or divisional in origin. The former were represented by the need for seminar rooms (a faculty deficiency?), and examination and sleeping rooms (a hospital responsibility). The latter included the frequency of duty nights on some services and the excessive service demands. The need for seminars on basic science subjects was identified by Dr. Yendt as a matter best dealt with at Faculty level. Other subjects of concern included organizational problems of conflicting rounds, the nature of case material, the disposition of "interesting or difficult" cases to the sub-specialty services at the expense of the teaching units and the favoured position of student interns in the allocation of teaching time.

The solution of the residents to the majority of the cited problems was to get rid of the sub-specialty wards.

Following the meeting in Jasper, the whole Department met at the University Hospital on February 15. The recommendations of the Jasper meeting were endorsed and in addition the members asked that the Department present a position paper to the Dean which was to make six statements:

1. That teaching demands were excessive and there was a need for more geographic full-time staff*
2. That salaries were not competitive and arrangements were unrealistic.
3. That there should be no further loss of positions to attenuation.
4. That the next five full-time positions be awarded to Medicine.
5. That there be a minimum of three full-time or F.T.E. positions in each division.
6. That the Department supports a practice plan in principle and that all hospital salaried positions for physicians be abolished and that the services provided by them be replaced by departmentally controlled special care units.

The Dean was made aware of these statements but all six had monetary implications and he was faced with inadequate funding for the Faculty by the University. At that time some faculty members questioned the need to remain a a faculty of the University and suggested with complete sincerity that the

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*At the time of the Accreditation there were 25 G.F.T. faculty at the University of Alberta Hospital, one at the Royal Alexandra Hospital, one at the Charles Camsell Hospital. Of these more than half were on soft funds. Part-time staff were distributed UAH 18, RAH 20, EGH 7, Misericordia 7.

Medical School seek support directly from Government, presumably through the Department of Health. The suggestion never took more concrete form although this solution continued to appeal to those who thought such an alignment would spare us the competition for funds with some thirteen other faculties in the University.

The Committee on Graduate Education, Dr. Anholt as the person responsible for Phase III, and each Divisional Head began to work toward solutions for the identified problems but it was recognized that some solutions must await changes beyond our control, specifically in the realms of building and financial support.

THE UNIVERSITY HOSPITAL

The Annual Report described "increasing pressure for more services and more sophisticated services and a simultaneous incessant rise in costs due to a double digit inflation which occurred during the year."

The staff of the Department of Medicine continued to add to the services available to patients at the University Hospital. Drs. Jacobs and McLean introduced a system for telephone transmission of electroencephalograms from Red Deer, providing a rapid diagnostic service.

After returning from a nine month study leave Dr. Nihei established a technique for detecting carriers of Duchene's dystrophy. In the Division of Pulmonary Diseases there was a noteworthy increase in the use of fiberoptic bronchoscopy and lung biopsy. Colonoscopy and cannulation of the common bile duct and pancreatic duct made there appearance in the Gastroenterology service.

The Division of Nephrology reported that thirty patients were on chronic dialysis in hospital and twelve at home. Twenty kidney transplants were completed. Dr. Silverberg created interest by his investigation of children with asymptomatic urinary tract infection and adults with asymptomatic hypertension. The Division of Cardiology reported the installation of 49 permanent pacemakers and an increase from 564 to 1918 invasive procedures over a four year period.

The Division of Endocrinology and Metabolism was finally granted approval to operate a Metabolic Day Care Centre in the vacated Butler Building. In July 1973 the Hospital was stressed by the additional burden of patients resulting from the strike of nurses at the Royal Alexandra Hospital. After accepting those patients who could not be discharged from the Royal Alexandra Hospital, we arranged a screening system for admission of only the most seriously ill until the nurses returned to work.

About this time Dr. Snell initiated a useful monthly meeting between the Chairman of Medicine, Dr. Read and himself. This presented an opportunity to discuss current problems in a less formal setting than that of the larger meetings.

The Hospital Administration expressed a desire to develop a system of periodic review of divisional heads to correspond to that applied by the University to departmental chairmen. This arrangement was adopted although I saw it as limiting the freedom of the chairman to recommend changes in divisional leadership simply because of the formality of such reviews. I was also unconvinced that a peer review was a better way of assessing the effectiveness of the director and indeed in small divisions it presented more problems than it solved.

The shortage of nurses became serious enough to initiate a plan to recruit 80 nurses from the United Kingdom. Dr. Snell denied the allegation of some medical staff that the University Hospital was more severely affected than the other metropolitan hospitals but twenty-one beds were closed for lack of nurses in August 1973. A meeting of the Joint Conference Committee (of the Hospital Board Executive and Medical Staff Advisory Board Executive) met in March to discuss both this matter and the proposed response of the Medical staff and Hospital to the Clarkson Study which was about to go to Government.

THE BUILDING PROGRAM

Graham Clarkson was appointed in 1972 with a mandate described earlier. He examined the floors occupied by Medicine in the Clinical Sciences Building (6, 7, 8, and 9) and thereafter we saw him no more until the fall of 1973.

In the spring of 1974 the report which Mr. Clarkson was prepared to submit to Government was made available to the Medical staff representatives and to the Hospital Board.

The Medical staff did not believe they were allowed sufficient time for this important task. They also thought there had been inadequate and perhaps inappropriate information provided with respect to our requirements. We did not know who would be making the final decisions.

Dr. Peter Allen, President of the Staff, and I as Chairman of the Medical Staff Advisory Board asked the Chairman of the Hospital Board to transmit our concerns to the Minister, pointing out that no plans had been requested of the staff until 2 months before the report was due and that the deadline was unreasonable.

The report was finally endorsed by both the Board and the staff, with some reservations. By the end of my term no decision or response had been received from the Government and it was to be another 18 months until initial acceptance of the proposals was announced.

ADMINISTRATION

In the spring of 1974 Hal Fearon told me he had accepted the Dean's offer to fill the position of Faculty Administrative Officer which had been held by Al Maiani. Hal had earned the respect and friendship of all our staff and had provided me with support and direction such that I suspected it would be difficult to replace him with a single person. I was sorry that my successor could not benefit from Hal's experienced guidance.

A search committee was successful in attracting applications from a number of suitable applicants and chose the third ex-serviceman to fill the position, Elwood Shell. With indoctrination by Hal and with his advice available from the thirteenth floor, Elwood took over the duties shortly before Dr. Brian Sproule assumed the position of Acting Chairman, July 1, 1974.

As recorded earlier the Hospital Administration arranged a monthly meeting with the Chairman of Medicine. In addition to this Dr. John Read instituted what were termed Administrative Ward Rounds once a month. These took place on each of the medical wards in rotation and were attended by Dr. Read, the Chairman, the appropriate Ward Chief and the Charge Nurse. These rounds seemed to offer an opportunity to discuss and solve problems which were often peculiar to one station and for a short time were successful. They were discontinued when other more pressing appointments for Dr. Read in particular, interfered too often with the planned meeting.

During the year, Dr. Cairns of the Royal Alexandra Hospital had spoken to the Dean about improving communication between the Faculty office and the teaching staff at the Royal Alexandra Hospital. A Joint Relations Committee was established, consisting of Drs. Scragg, Varvis and Cairns from the Royal Alexandra Hospital and Dr. Grisdale, Assistant Dean and the Chairmen of Surgery (Macbeth) and Medicine (Fraser). It was also agreed that the President of the Medical Staff of the Royal Alexandra Hospital would attend meetings of the Executive of the Faculty Council as a observer and that Dr. Grisdale would have a similar priviledge extended by the Medical Advisory Committee of the Royal Alexandra Hospital. This must have been a shortlived arrangement since I do not believe it lasted much beyond its first few months of life. This was unfortunate because it might have improved the exchange of views between two major departments and with one of our major teaching hospitals.

THE FACULTY

As of February 1974 ten members of the Department were salaried in whole or part by the Hospital. Because of added clinical responsibilities in the Aberhart Hospital, the Division of Pulmonary Diseases recruited another member to be employed by the Hospital with a modest teaching stipend from the Faculty. Dr. F.G. Buckle, a graduate of Saskatchewan, was appointed in July 1973 and remained on staff until 1975 when he left to practice in Calgary.

Dr. Ken Thomson, a senior member of our part-time staff, retired in 1974. Ken was doubly certified in Internal Medicine and Psychiatry but his interests extended to all aspects of medicine and his contributions to the Faculty and to the profession had been many, including his service as president of the Canadian Medical Association and Chairman of the Economics Committee.

Dr. Ray Ulan resigned September 1973 from his position as Director of Regional Dialysis Program for Northern Alberta to accept a position in Nephrology at the University Hospital in London, Ontario. Ray was a graduate of Alberta (1961) and took graduate training here and at the Royal Victoria Hospital, Montreal before obtaining his F.R.C.P.(C) and returning here in 1967. The happy sequel to the story is that he has since returned to the University of Alberta Hospitals to resume his work in the dialysis program (1982).

Dr. Patricia Lynne-Davis qualified in 1961 at the London Hospital Medical School and emigrated to Canada to begin graduate training here in 1962. After working as a Research Fellow in the Pulmonary Laboratory she left to work for her doctorate in Physiology at McGill, returning to the University Hospital in 1969 as Assistant Clinical Professor in the Division of Pulmonary Diseases. Pat developed a reputation as a capable researcher and an excellent teacher as well as a competent physician. It was with great regret that we received her resignation to go to Stanford in June 1974.

The new and expanding medical school in Calgary persuaded Dr. Mo Watanabe to join them in July 1974. He had been a valued member of our department since coming to Edmonton in July 1967 to a joint appointment in Biochemistry and Medicine. He obtained his medical degree (1957) and his Ph.D. (1963) in Biochemistry from McGill and did his graduate training at the Royal Victoria Hospital (F.R.C.P.(C), 1963). After three years in Molecular Biology at the Albert Einstein Centre in New York he accepted a position here in July 1967 and became Director of the Division of Endocrinology and Metabolism in 1968. His contributions were made in every field - research in which he continuously obtained support, teaching both undergraduate and graduate students, the practice of medicine and in departmental administration. In Calgary he later

became Head of the Division of Medicine and is currently Dean, a recognition of his wide ranging talents.

Another member who had made much appreciated contributions to the Department, the Faculty and the Hospital was Dr. Adam Little whose resignation I received in February 1974. Adam had occupied several different positions in the medical community since arriving as a teaching fellow in January 1956. After obtaining his medical degree from Manitoba in 1942 he practised medicine in Dauphin for nine years before leaving for three years of graduate work in Medicine at New York University. For the first three years in Edmonton after obtaining his fellowship of the Royal College he was in private practice and taught in Pathology and Medicine. In 1960 he was appointed Director of the Outpatient Department, a post which he held until 1965 when he left to become Director of Cancer Services for a year. Following his re-appointment to the G.F.T. staff in August 1966 he became Director of Continuing Medical Education for the Faculty for two years. Adam's contributions were numerous but he is perhaps best remembered as a compassionate and skilled physician. He spent much effort trying to expand the Division of Hematology which he directed but he faced the twin difficulties of deficient funding and in establishing territorial rights with the Department of Clinical Laboratories. Patients with hemophilia will long remember his organization of a treatment program for those from this part of the Province. It was with universal regret that the Department saw him off to an equally challenging position as Chief Medical Officer of the Worker's Compensation Board of British Columbia.

The hazard of losing staff in 1974 was not only the loss of their skills but the possibility that the position might disappear as well. In an attempt to stay within budget musical chairs was played with vacant positions and we hastened to get the Dean's permission to set up search committees to fill these vacancies before we lost them to another department. This activity extended beyond my term and that of Dean Mackenzie who relinquished the leadership of the Faculty to Dr. D.F. (Tim) Cameron in the summer of 1974.

CONCLUSION

What I have written must of necessity reflect my personal view of events. Nevertheless I hope that I have been able, by reference to as many records as were reasonably available, to accurately describe much of what influenced the development of the Department through those eventful five years.

In doing so I also tried to paint the picture broadly enough, by describing matters which were happening in the Faculty as a whole, in the Hospital and in the University, to demonstrate our interdependence.

This story was not intended to present statistical data concerning budgets or research funding although such information is included when it formed part of the narrative.

It was impossible to catalogue the contributions of each member of the Department and I apologize to all those whose accomplishments and assistance were unlisted but no less appreciated than that of those whose names appear in these pages.

What changes took place between 1969 and 1974? There were a number:

The change in the curriculum; the sub-specialization of the Department; the entry of the Hospital into the provision of professional services in special care units; the re-organization and more structured nature of graduate training with the transfer of responsibility from the Hospital to the Dean's office to the Department; the recognition that the Department must recruit a nucleus of physician-scientists.

Perhaps this story will preserve some information which would otherwise have disappeared. If it does so, and if it proves to be of interest to others who lived through these years it will have served the purpose for which it was written.

APPENDIX A

PROFESSIONAL EARNINGS-CLINICAL FACULTY, DEPARTMENT OF MEDICINE

The Department of Medicine believes that:

1. Its members have responsibilities to fulfill as consultants in the University Hospital which is not only a teaching hospital but a provincially owned referral center where special diagnostic facilties are provided for the people of this province.
2. That the provision of such a consultant's service is a necessary function of their roles as teachers of under-graduate and graduate students.
3. That in providing such a consultant service they are in competition with other centers both within and outside the Province of Alberta: That their success in attracting referred patients depends upon their personal relationship with referring physicians who are under no obligation to refer patients to the University of Alberta Hospital.
4. That the Faculty of Medicine is in a unique position within the University community in having to provide its own "laboratory material" in contrast to other professional groups such as engineering, law and chemical engineering. In the light of this observation we do not believe that full-time clinical members of the Faculty of Medicine should be expected to carry the added work and responsibility without appropriate recognition and a reward.

It was recognized in 1953-54, at the time of appointment of the first full-time members of the Clinical Faculty, that excessive involvement in private patient care might be detrimental to teaching and research. Two deter-

ents were established: A limitation of time for private practice and a limitation of earned income.

It has become obvious that the limitation of income can become a punitive restriction. It is inherent in the development of a referred practice that the practice grows when the consultant give exemplary service. It is obvious that the responsibility to patients and to referring physicians makes it impossible to refuse to see further patients when one reaches an optimal load. Should this be done it results in a complete loss of referrals from that source since alternative sources of consultation are always available and the referring physicians do not appreciate the reasons leading to a restricted consulting practice, particularly in a provincially supported diagnostic center.

Unless an increase in staff occurs at appropriate intervals some of the current staff are faced with a continuing excessive volume of referred work, over which they have very little control. Their work, in evenings and on weekends, results in income in excess of the limit and they understandably have the feeling that they are penalized by the financial arrangements.

Two further observation may be made:

1. The original concept of a ceiling on private consulting fees incorporated the belief that there would be no excess earnings generated if the system worked effectively. That is to say, if all members stayed below the ceiling the relative proportion of time allotted to teaching and research versus patient care would be optimal. For this reason excess earning should never be considered to be an integral part of Faculty or Departmental budgeting, no matter how helpful such funds may be.

2. The Departments of the Faculty of Medicine are less rather than more expensive to operate than several other comparable Departments in the University. For example, the Department of Medicine with 20 members had a net operating budget in 1969-70 of $391,590.00: Chemical and Petroleum Engineering with 14 full-time members had an operating budget of $611,950.00 and Electrical Engineering with 21 members $658,735.00. There is therefore little justification for suggesting that the Departments in the Faculty of Medicine should subsidize their own members through professional earnings because of any excessive operating costs incurred in running a University Faculty of Medicine.

FUTURE ARRANGEMENTS CONCERNING PROFESSIONAL EARNINGS

The ideal situation would incorporate only sufficient clinical practice for each clinical appointee to satisfy the requirements that he be active in the current practice of Medicine and remain a good clinical teacher with an adequate patient load to satisfy this need. No specific ceiling to income from consultation should be established but the Departmental Chairman would have to accept the responsibility for "policing" the activity of each member of his Department by demanding appropriate time and productivity in teaching, research and administration. We believe such an ideal arrangement would be difficult to reach and even more difficult for the Chairman to supervise.

It therefore seems necessary to consider the alternative, namely that of a ceiling to fees from consulting practice. Such a ceiling may be "hard" or "soft". If we accept the premise that earnings beyond a realistic ceiling represent a failure to function ideally in a full-time position, and if we acknowledge that a soft ceiling may act as an inducment to take on excessive patient responsibility, a hard ceiling would seem desirable.

LEVEL OF CEILING

The Medical Faculty is in competition with other medical schools and the total income of members must also bear some realistic relationship to earnings in private practice.

This might be done in one of two ways:

1. The ceiling might be calculated by determining the difference between the salary of an Assistant Professor (U of A), two increments from the top of the rank and the average net earnings of a practicing physician in Alberta. For example:

Net earnings of the average Alberta physician (1967)	$28,000.00
Assistant Professor two increments from maximal	$12,750.00
Permitted income from consultation for all ranks	$15,250.00

This should be adjusted in either direction from year to year with the changes in reported income from the average physician in the Province.

2. The ceiling might be arbitrarily set at a realistic amount, which, for persons with the qualifications for medical school staff might be $20,000.00. This would apply to all ranks and could be reviewed every 5 years.

EXCESS EARNINGS

We believe that it is important for incentive and initiative to be maintained at the Divisional and Departmental levels. This can be done by assur-

ing that funds generated from patient care revert in substantial proportion to these levels of administration. It is in the interest of the Divisions and Departments to make sure that patient care is allotted in such a way that optimal use is made of the talents and interests of each member. Adequate control over professional fees generated within Departments also encourages and permits arrangements whereby new staff members can be brought into Departments with a guarantee of professional earnings sufficient to attract them.

In designing a plan for the distribution of excess earnings it seemed reasonable to take into consideration the teaching load and the number of available full-time staff. A survey of the new curriculum shows that Medicine and Surgery will carry heavy loads (in the Systems Teaching Medicine will be responsible for 300 of 480 hours). Obstetrics Gynecology, Pediatrics and Psychiatry carry medium loads and Anesthesia, Ophthalmology and Radiology lighter loads.

Our Committee has suggested that the division of funds in excess earnings be as follows: Small Departments 5%, Medium Departments 10%, Large Departments 20%, Dean's Office 15%.

Recognizing three small, three medium and two large Departments this would constitute 85% of the generated funds and the remaining 15% would revert to the Faculty to be administered by the Dean.

Using last year's figures and a hard ceiling of $20,000.00 we have calculated that the contribution to the pool of Excess Earnings from the Department of Medicine would exceed the amount contributed last year under the old scheme by approximately $4,000.00.

All Departments would benefit reasonably through such an arrangement and the Faculty as a whole would have access to a smaller central source of funds from the Dean's office which could be used to strengthen weaker areas.

APPLICATION

It is understood that the present staff will be permitted to choose whether they wish to accept a new arrangement for professional earnings or whether they prefer to remain on the present system. It is also understood that any new formula which is agreed to would apply to all new staff members.

It is strongly urged that one system and one source of payment apply to all appointees in clinical departments at the University Hospital. The single source should be the University and if other sources of funds such as the University Hospital or other professional earnings are used to generate part of the salary this should be paid by these sources to the University. Unification of the appointments and the salary arrangements will prevent comparison of two or more different arrangements. In addition to this all recent applicants to staff have indicated a preference for an appointment through the Faculty of Medicine and the University.

RSF/ec

May 1970

APPENDIX B

REPORT OF AD HOC COMMITTEE ON DEPARTMENTAL PRACTICE PLAN

The Committee agreed that the present system of individual practice is not ideal for academic performance and recommends adoption of a departmental practice plan to improve teaching and research in the Department. The following are guidelines agreed to by the Committee. We propose that this report be circulated among all members of the Department and a meeting be held in early September to discuss this proposal.

Main Objectives and Principles Pertaining to the Proposed Plan

1. To enable the members to perform the academic activities (teaching, research and administration) to the fullest extent without financial sacrifice.
2. To make it possible to attract and retain outstanding individuals to this Department by making it possible to guarantee an adequate and competitive income above the institutional salary.
3. We contend that a degree of clinical activity is essential for the full-time staff but recognize that teaching and research can be hampered by excessive involvement in patient care. Therefore, we recommend a "hard ceiling" to discourage such tendency.
4. Some of the geographic full-time members have been employed by the hospital, creating a dichotomy within the Department of Medicine of this University. We recognize such a division is undesirable and therefore recommend that the hospital appointees be brought into the same arrangement as the rest of the full-time staff under the proposed plan.

5. We recognize that a continued contribution of the part-time staff in teaching is essential to this Department. Therefore, every effort should be made to avoid creating division between the two groups, and the proposed plan should provide the opportunity for part-time members to join the plan, if desired.

Specific Recommendations

1. The plan will be managed by a Board elected by the participating members. The Departmental Chairman shall be Chairman of the Board.
2. The General Faculty Council of this University has ruled that professional earnings are a departmental matter. Accordingly, the present arrangement concerning "excess earnings" should be terminated when the Departmental Plan becomes effective. (This has been suggested by Dr. D.F. Cameron.)
3. Participation in the Plan should not result in a significant decrease in any members current income. This Committee believes that the present net income of the members of the full-time academic staff is barely competitive with a number of other Canadian medical schools, and is not excessive in the academic market-place.
4. Any surplus funds at the end of the fiscal year will be distributed among the participating members.
5. The members who are not receiving institutional fringe benefits shall receive fair compensation for this.
6. The Plan should make provision for additional secretarial staff for participating members when deemed necessary.

7. The income of each member shall be reviewed annually and agreed to by the individual and the Departmental Chairman as fair and equitable.
8. The Plan will pay expenses for office space, equipment, supplies and managerial and office staff as agreed to by the participating members from time to time.
9. The income to the Plan shall include:
   a) Professional income from patient care
   b) Incomes from the special funds generated by the participating member
   c) Institutional salary is not contributed to the Plan but the salary is taken as part of the total income specified in recommendation (12).
10. We recognize the need to provide an incentive for generation of income to the participating member and the divisional group.
11. Annual income from the Plan shall be determined using criteria including:
   a) Academic rank and seniority
   b) Individual's "market value"
   c) The performance in teaching, patient care, research and administration
   d) The effort to generate income.
12. The annual income range consisting of institutional salary if any and income from the Plan shall be: (including the expenses mentioned in (13))

	Minimum	Maximum
a) Non-practicing member	To be determined on individual merit, by the Departmental Chairman and a representative of the group	
b) Assistant Professor or equivalent	$ 22,500	$ 32,500
c) Associate Professor or equivalent	27,500	45,000
d) Professor or equivalent	32,500	55,000

13. In order to eliminate unnecessary red tape, and to discourage "free spending" of funds, and also to keep the administration expense to a minimum, each member shall pay for his own automobile expenses, books and journals and convention attendance.

14. Members of the Plan shall devise an equitable method for providing some continuing income from the Plan to members on Sabbatical leave from the University, recognizing the mutual benefit of such an arrangement over the course of time.

Aug 1972

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